Hospital Library
APR 6 1944

SPITAL CARE FOR ALL
Page 49

the MODERN HOSPITAL

VOLUME 62 APRIL 1944 NUMBER 4

"and the situation is well in hand—"

ALL credit to our fighting marines who have done so much to establish a "bridgehead of victory." And all credit to our intrepid military medical men who plunge right along with them to perform miracles of healing under the most trying conditions. Staunch allies of the surgeon on military fronts throughout the world are Sklar surgical instruments, always dependable in moments of crisis.

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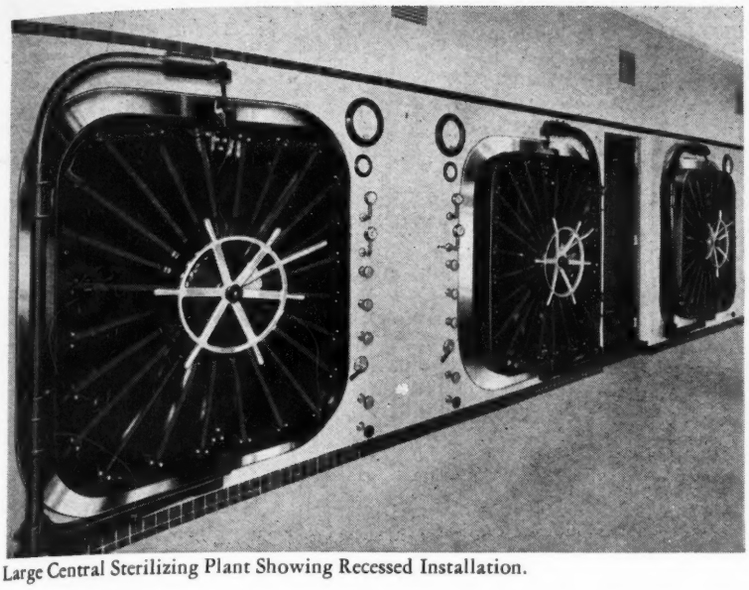
LONG ISLAND CITY, N. Y.

Please protect and conserve your surgical instruments. Military needs are wide and urgent. We will do our best to fill essential civilian requirements.

WITH THE U. S. MARINE LANDING FORCES



Large Central Sterilizing Plant Showing Recessed Installation.

CLIMAX AUTOCLAVE STERILIZERS

for SURGICAL, LABORATORY and INDUSTRIAL USES

The most complete line produced in America—a size and type for every need—for the sterilization of surgical goods, instruments, utensils, solutions, serums, drugs, clothing, mattresses, brushes and commercial products. "Climax" Sterilizers are the product of 45 years' experience. They embody the highest standard of efficiency, durability and excellence of design. They are used widely in Hospitals, on Naval Ships, in the Field, Blood Bank Depots, Decontamination Stations, Laboratories, Pharmaceutical, Chemical and Industrial Plants.

Being well ahead on war production, part of our manufacturing facilities are now available for civilian hospital and industrial requirements. If you are planning new construction or modernizing present facilities, our Engineering Staff will be glad to recommend suitable apparatus to meet your needs and provide necessary plans, specifications and technical data. Write for catalog and full information.

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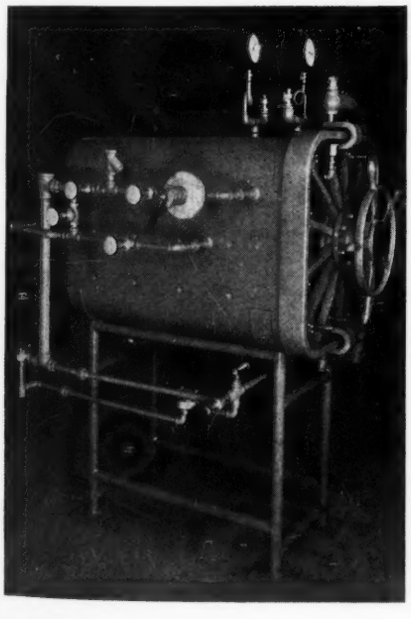
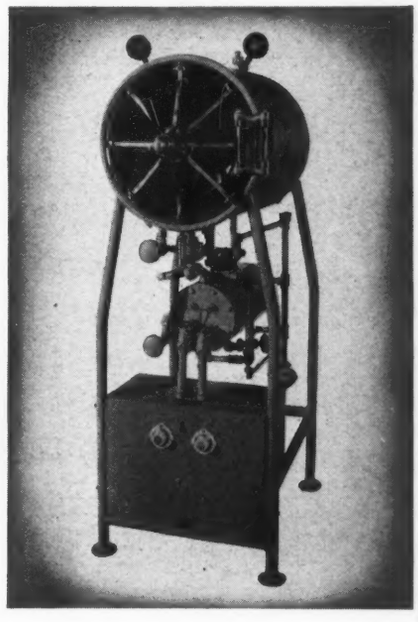
155 East 23rd St., New York 10, N. Y. **Established 1898**



Climax STERILIZERS

(Left) Autoclave for Penicillin Plant
(Below) Mobile Sterilizer built for Army Medical Department
(Right) Small Dressing Sterilizer built for Shipboard Use

OTHER TYPES FOR ALL STERILIZING NEEDS



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Published monthly and copyrighted, 1944, The Modern Hospital Publishing Company, Inc., 919 North Michigan Avenue, Chicago 11. Otho F. Ball, president; Raymond P. Sloan, vice president; Everett W. Jones, vice president; Stanley R. Clague, secretary; James G. Jarrett, treasurer. North and South America, $3 a year; foreign, $4. Single copies: current, 35c; back, 50c to $1. Entered as second-class matter, Oct. 1, 1918, at the post office at Chicago, Ill., under act of March 3, 1879. Printed in U.S.A.

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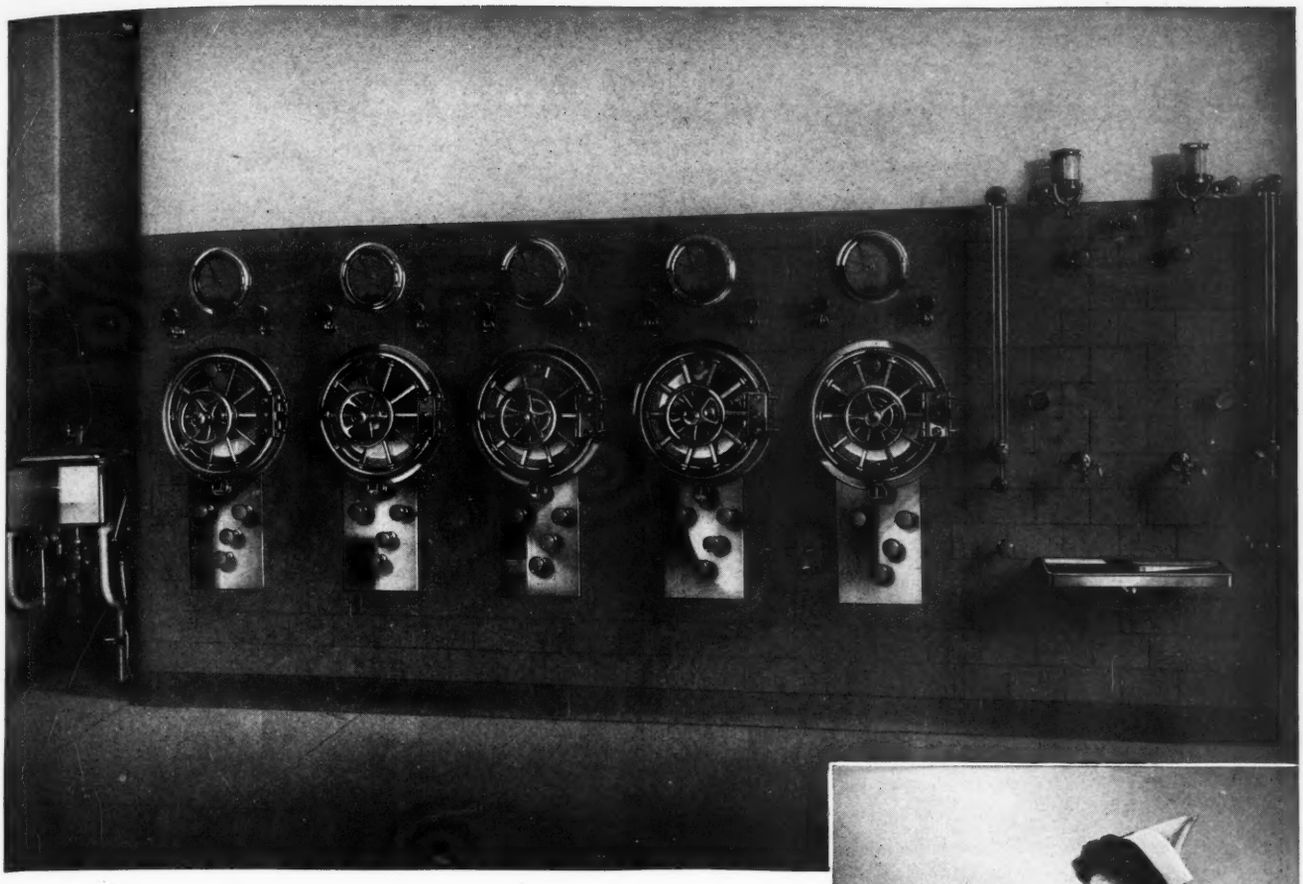

AIDING HOSPITAL SERVICE . . .

With personnel shortages continuing, the installation of time- and labor-saving equipment in strategic locations around the hospital is extremely helpful today in maintaining standards of hospital service. Let us send descriptive catalogs of essential items—

Sterilizers	Maternity Equipment
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Above: The efficiency and durability of Scanlan-Morris sterilizers give full-time cooperation in today's heavy surgical schedules.

Right: Scanlan-Morris bedpan apparatus speeds up the work on the floors and insures thorough care of patient's bedpans and urinals.

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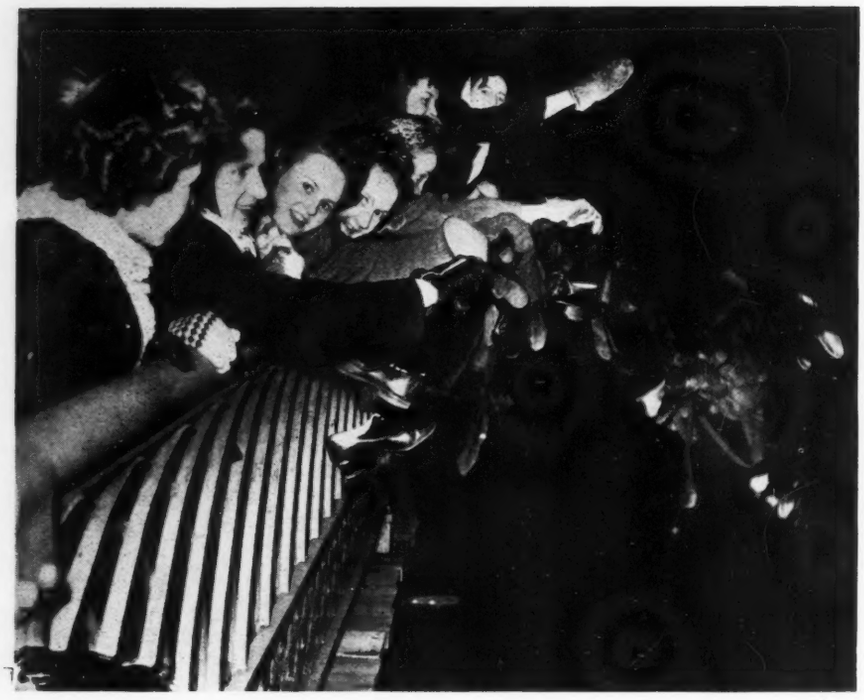

Acme

An old school custom at Bethesda Hospital, St. Paul, Minn., is the tossing of worn black shoes into the Mississippi River when the student nurses complete their probationary period and go into "whites." The girls hang over the railing of a high bridge and at a signal hurl into the Father of Waters the dark working shoes that they will wear on the wards no longer. This year, however, the ceremony did not seem consistent with the O.P.A.'s shoe rationing program. Not to break with school tradition, the girls tossed the shoes but, like Pill-Jerk Peter, they had attached strings to them and the shoes were retrieved for later use on days off duty.

To a Queen's Taste

One section of the school of nursing library at Queen's Hospital, Honolulu, has been set apart for items connected with the life and times of Queen Emma Kaleleonalani. This specialized collection of Hawaiiana is the idea of the director of nursing education and the archivist.

Queen Emma and her husband Kamehameha IV were the founders of the hospital, the cornerstone having been laid in July 1860. Before her royal marriage, Emma was the adopted daughter of Dr. C. B. Rooke, physician to the king, and thus had an intellectual as well as a warm emotional interest in the health of her people. She was educated by Mr. and Mrs. Cooke of the Royal School for Young Chiefs. The king died young and the welfare of the Hawaiian people thereafter rested on Queen Emma.

The infant collection has great potentialities for the queen was a traveler and on a European journey in 1865 made friends with Queen Victoria, Napoleon III and the Empress Eugenie.

Queen's Hospital always celebrates Queen Emma's birthday; this year an open house was held on Sunday, January 2, at the new school building.

Musical Moments

Our contention is that cantatas are likely to be dreary affairs to everyone except the singers. But, oh, how the singers love to soar!

On the theory that even cantatas can be fun for the participants, at least, what a tremendous recreational and therapeutic aid can choral singing of music of any or all types become under proper leadership.

The mental disease hospitals know this, as witness Norwich State Hospital's music program at Norwich, Conn. The hospital has a professional musician to head up the program, Mrs. Jarrot Harkey. Regular group singing hours are held on the wards.

There is a Catholic patients' choir for masses and Catholic devotionals, and another choir for the Protestant Sunday

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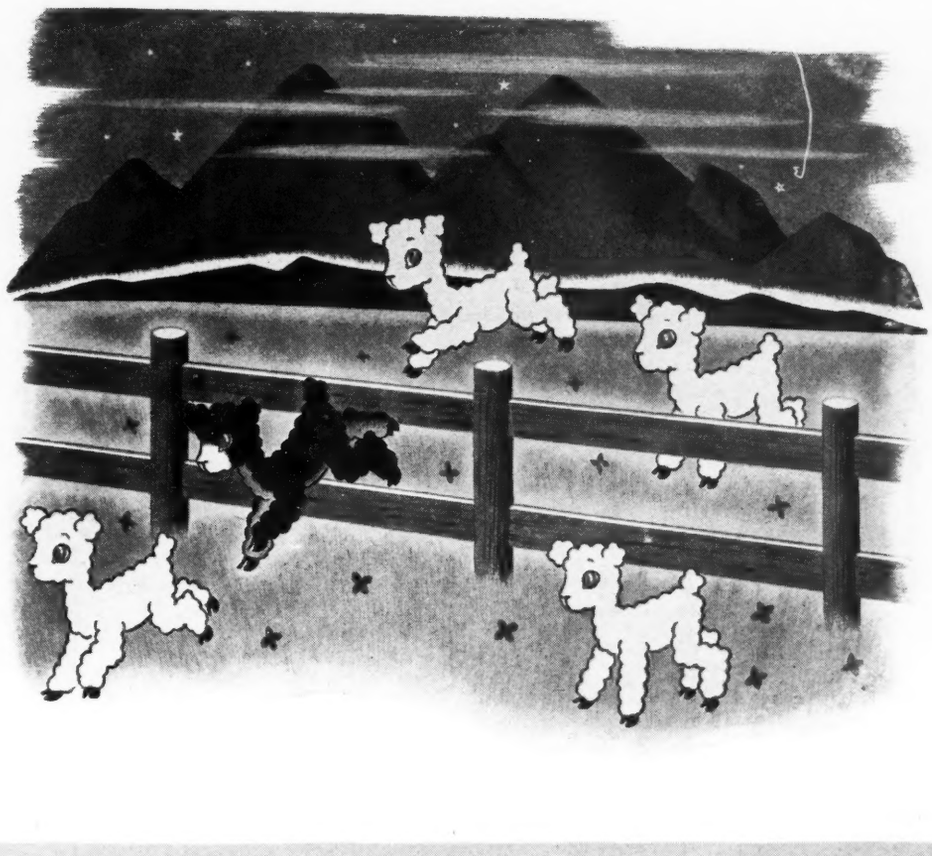

Communion with Morpheus

For sure-fire nighttime sedation, sheep counting isn't always dependable even though a black one is brought in now and then for variety. Sick people, particularly, like a more positive means of getting a night's sleep. Sound rest contributes to recovery.

Physicians who order a bedtime dose of 'Seconal Sodium' (Sodium Propyl-methyl-carbinyl Allyl Barbiturate, Lilly), 1½ grains, know that they are likely to find a grateful and perhaps more cheerful patient when morning rounds are made. 'Seconal Sodium' exerts its effect so quickly that little time is available for sheep counting, even if the patient is so inclined. Sedative effect is of short duration, but long enough to permit the onset of natural sleep. 'Seconal Sodium' is available in practically every hospital pharmacy or drug room, subject to the doctors' orders.

ELI LILLY AND COMPANY • INDIANAPOLIS 6, INDIANA, U.S.A. Lilly

services. Mrs. Harkey encourages the patients to choose their own music and lead their own groups.

This year a men's chorus, a women's chorus and a mixed chorus are in training. An instrumental group rehearses regularly. Individual lessons are given in voice, piano and instruments.

On Easter and Christmas there are pageants in which both patients and employes take part, with the choruses and orchestra carrying off the chief honors.

The Norwich program has long ago progressed beyond the stage at which only the participants enjoy the music. The listeners take genuine pleasure in the trained voices and well-rehearsed orchestra.

Easter Service

There won't be an Easter parade at Wesley Hospital, Chicago, for the bed patient's mind is not distracted from the real exaltation of Easter concept by thoughts of how rain may spot the new Easter bonnet or the fine top hat. But there will be triumphant Easter music and a moving Easter sermon.

Their thoughts have been much on Easter at Wesley for vesper services have been held during Lent.

The special Easter service is not an unexpected occasion for the further reason that it is only an outstanding edition of the regular Sunday religious series inaugurated at Wesley in February by its new chaplain, Rev. Russell L. Dicks. Each week a microphone is set up, connected with the hospital's public address system and a half hour service is broadcast to the patients' pillow receivers.

Wesley's services last only half an hour, from 10:30 to 11 a.m., after which patients may tune in on outside religious services if they wish.

Because Wesley has 400 beds given over to Navy men at present, the Sunday music may come either from the nurses' choir or from a Navy choir. The sermon may be given by the hospital chaplain or by Rev. F. F. Tower, senior chaplain at Navy Pier. Twelve minutes is allotted to the sermon; the rest is music.

"A helpful by-product of this Sunday service," the Rev. Mr. Dicks declares, "is that as a result of it many requests for visits reach the chaplain's office. It helps to acquaint patients with the new chaplaincy service and makes them feel that the chaplain is their friend."

Lobby Concerts

While discussing Wesley and its Sunday features, we must tell you of the boon that a Sunday afternoon broadcast of sacred music has proved. Visiting hours begin at 1:45 p.m. and with 400 Navy boys in the building, along with all the other patients, the din of the visitors' arrival is considerable.

Wesley's lobby is much like a cathedral and it seems highly fitting that ecclesiastical music should soar as one steps inside. A record library of sacred music has been built up and for half an hour at visiting time each Sunday it is played over the lobby loud-speaker. It makes the afternoon much more tolerable for hospital attendants and undoubtedly creates a good impression on the visitors.

Incentive for House Officers

Another name among house organ editors that will live is that of the late Harry D. Clough who did such an outstanding job with the mimeographed *News Letter* of Rochester General Hospital, Rochester, N. Y.

The Harry D. Clough Memorial Prize has now been established for the house officer who contributes most to the success of the weekly staff conferences during each year in selection of clinical material, quality of case presentations and discussions. The name of each successive winner will be placed on a memorial plaque in the conference room and a $25 cash prize will be given. Doctor Clough was assistant medical

. . . . . a silly smiling ecstasy on his face

HIS NOSE pressed putty-flat against the glass . . . . . his hat pushed back . . . . . a lovely silly smiling ecstasy on his face . . . . . to see his *son* . . . . . his first.

The proudest paper he could own is one that has his new son's name . . . . . and *his* and Mom's . . . . . and *yours* . . . . . a document that holds authority and love and deeper sentiment . . . . . a Hollister birth certificate that's fine to look at and touch and strong . . . . . to last for years . . . . . to say to *any*one who'd *ever* have to know, "*This* man was born *here* on *this* date . . . . . of *this* woman" (and a man who stood at a plateglass window *years* ago with a silly smiling ecstasy on his face).

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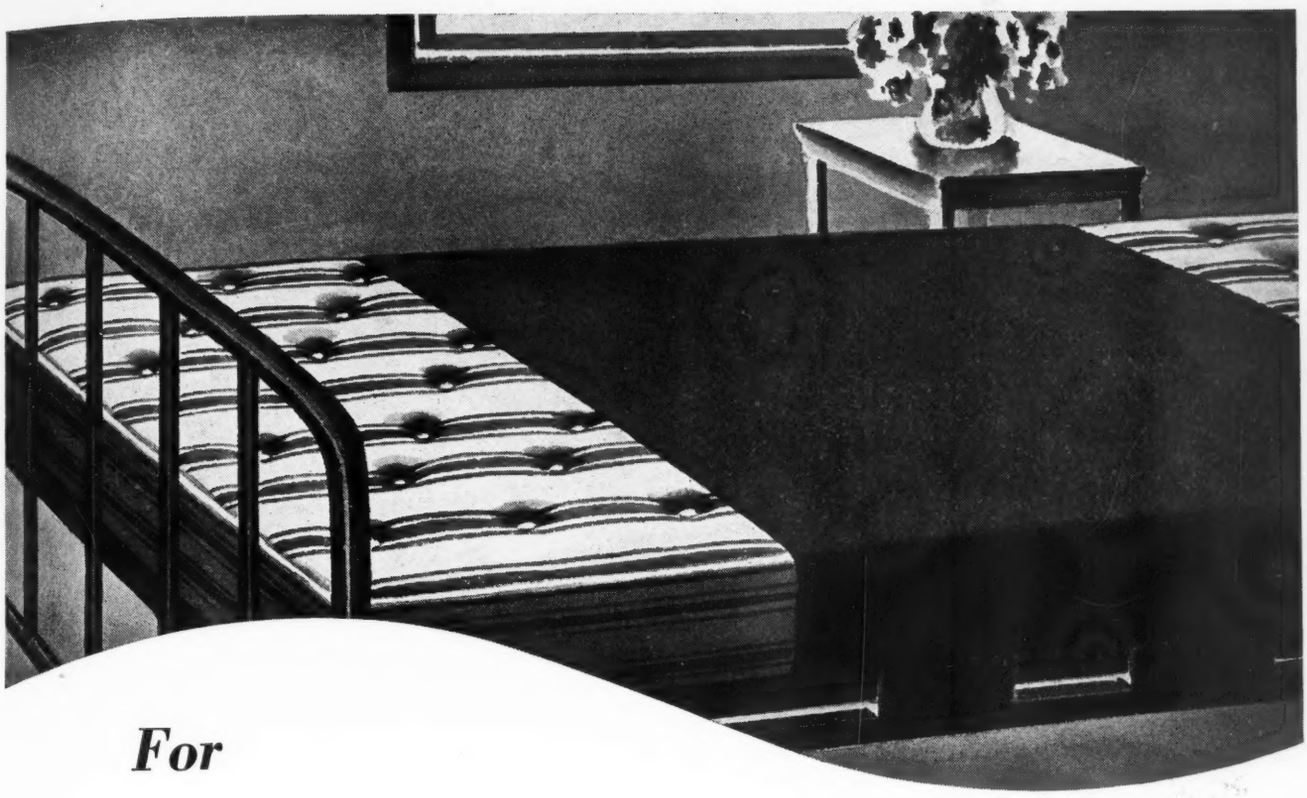

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A New Oil and Urine Resistant Sheeting

A synthetic product—not a substitute for rubber sheeting, but actually a superior waterproof product. A Fillman Textile Specialty of outstanding merit.

Fillman Oil and Urine Resistant Sheeting is coated on both sides with a chemically inert product which is not subject to oxidization or ultimate decomposition as are rubber-coated fabrics. It is more resistant to mineral and vegetable oils and greases. Unlike other synthetic resin coatings, it is not thermoplastic and, therefore, is less affected by temperature extremes.

Simple, proper care will insure long life. Wash with warm water and soap to remove excessive amounts of oil or greasy medication. Allow to dry under normal conditions—never on steam pipes or over a radiator.

It may be sterilized with 5% Phenol or Lysol solution, or other similar disinfectant. Immerse in autoclave under 15 pounds steam pressure for 20 minutes at 110° F. Expose to direct sunlight. If alcohol is used, apply to surface only.

Fillman Oil and Urine Resistant Sheeting meets National Bureau of Standards Specification CS 114-43 and Federal Specifications E-ZZ-S-311 A, Type C, 12/4/42. This Oil and Urine Resistant Sheeting comes in 36 inch—25 and 50 yard rolls. Maroon color only.

Fillman is always in touch with the latest developments in hospital fabric supplies. That is why you can safely "centralize your buying" with Fillman, and be sure you will obtain the latest approved hospital fabrics. If you have special fabric needs, we will gladly endeavor to fill your requirements. Write Dept. M-4.

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Blankets	Gowns	Table Linens	Sheets
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director of the hospital and did much to improve staff conferences, as well as public and personnel relations.

Young Volunteers

The Girl Scout hospital aide is now working cheerfully in her after-school hours and week ends in more than 500 American hospitals. She is mending rubber gloves, caring for flowers, running errands, changing babies' diapers, getting the youngsters in the children's ward ready for supper and helping to feed them, delivering supper trays, assisting the dietitian, keeping the supply room in order, getting rooms ready for new patients, cleaning and sterilizing instruments and setting up technicians' trays.

Many a busy superintendent of nurses has taken the time to write to Girl Scout officials that "these girls are not only contributing valuable service but also bringing to the hospital an enthusiasm that is inspiring to both nurses and patients."

With an eye on postwar needs, the program planning division of the national Girl Scout staff has drawn up a basic training course and guide for leaders of Girl Scout occupational therapists aides, which has been fully approved by the American Occupational Therapy Association.

Paul Parker

Although the training in this work is just getting under way, Bridgeport Hospital, Bridgeport, Conn., has had Girl Scout aides working in the occupational therapy department for more than a year. They have been doing mostly diversional and crafts work with women medical and surgical cases and with men surgical and orthopedic cases, preparing materials in the shop, instructing the patients in crafts, finishing articles the patients have started and helping with the selling of some of these articles in the hospital lobby.

Senior scouts, 16 and up, who have had training in arts and crafts will be eligible for service as occupational therapist aides. Younger scouts will work in their troop meetings on such projects as making frames, stretching burlap and outlining designs for small hooked rug projects. These with full directions and needles will be placed in an envelope ready for use in occupational therapy departments.

Girl Scout troops in Staten Island have been busy salvaging materials for Halloran General Hospital.

Has Own Scout Troop

Rotary convalescent home of James Whitcomb Riley Hospital, Indianapolis, has a Girl Scout troop of its own. A troop in the city comes to visit the hospital scouts regularly, bringing materials and assisting them.

So that the young patients will not feel this is a one-way proposition, they are often asked to complete a project for the city troop. Recently the city troop held a cook-out for the patient troop. The patients planned the menu; the city troop took the patients out into the hospital grounds in wheel chairs and on stretchers, built the fire and did the cooking and serving to the excitement and joy of the patients.

IT'S SO PLEASANT AND QUIET

Replace calls, bells and buzzers with a Cannon *silent* doctors' paging system. Seeks out as many as four doctors at one time without a sound—effectively—anywhere in the buildings or on the grounds.

Easy to use, too. Your switchboard operator simply dials the numbers—one to three digits—on a single telephone type dial.

Cannon—pioneers in electric circuit development—are specialists in hospital signal systems. Study the Cannon catalog to learn how the efficiency of your organization may be improved.

Cannon Hospital Signal Systems include a complete line of . . . Bedside Calling Stations • Nurses' Call Annunciators • Supervisory Stations • Corridor Pilot Lights • Doctors' Paging Systems • Aisle Lights • In and Out Registers • Explosion and Vapor-proof Switches • Elapsed Time Recorders.
WRITE FOR LATEST REVISED BULLETIN. Address Dept. A-124, Cannon Electric Development Company, Los Angeles 31, California

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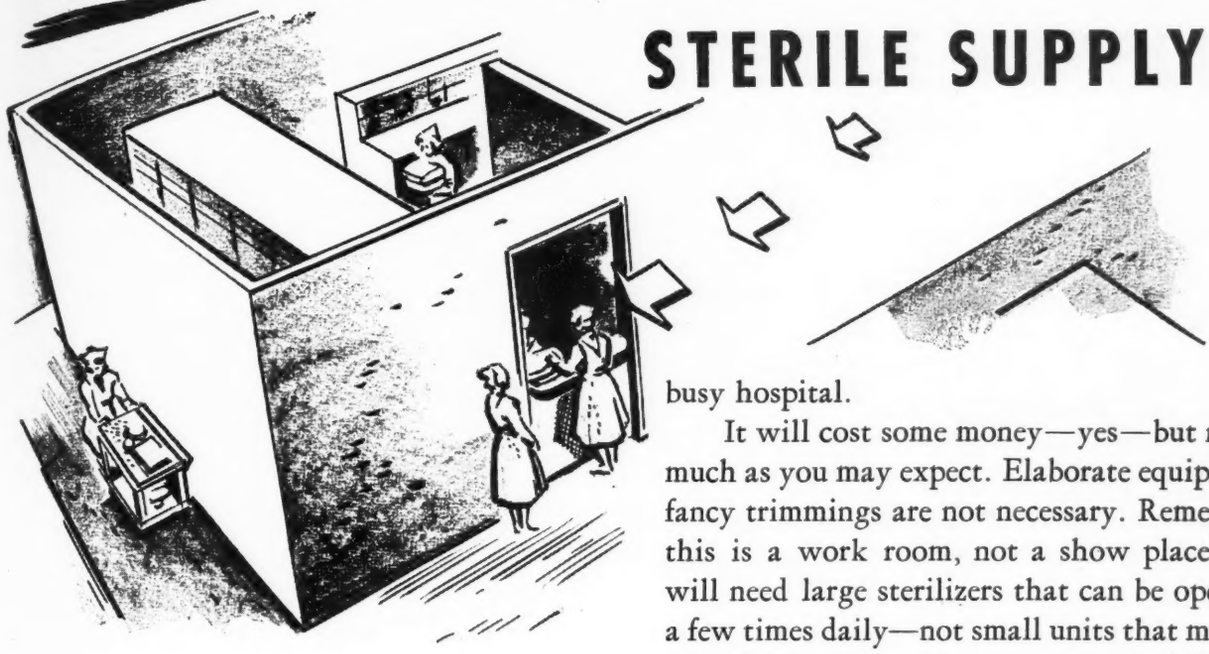
More about that CENTRALIZED STERILE SUPPLY



Never before in the history of hospitals has there been the imperative need that now exists —for the well organized, efficiently managed, comprehensive Centralized Sterile Supply.

Why? Because with the present (and growing) shortage of nurses it has become necessary to employ unskilled personnel. In sterilization, this can be done safely only when the details of preparing goods, loading the sterilizers and operating them is strictly and continuously supervised by an individual well grounded in the fundamentals—and whose sole business it is to manage the work.

Divorce this highly important supervision from the duties of the already over-worked Operating Room Supervisor. Provide that thorough-going supervision for your Central Sterile Supply, build up stocks of sterile supplies and maintain them. Be ready for those emergencies when they occur—with certainty that nothing has been neglected.

It can be done, it has been done even under the present emergency conditions. Those who have organized Central Sterile Supplies will be the first to advocate this system as a "must" in the operation of any busy hospital.

It will cost some money—yes—but not as much as you may expect. Elaborate equipment, fancy trimmings are not necessary. Remember, this is a work room, not a show place. You will need large sterilizers that can be operated a few times daily—not small units that must be operated continuously; one or two adequate sinks for the clean-up section; perhaps a water still; good work tables and plenty of storage space for sterile and unsterile supplies.

Arrange your space most carefully to provide for continuity of movement of supplies through the department—to avoid confusion and unnecessary work. Doors should be of the dutch type, half length, to prevent entrance of all outside personnel.

We can help you to develop and organize such a department. Do not worry too much about the location if it is not entirely central. The most important thing is organization and management. Some of the most successful Central Sterile Supplies are remote from the center of the hospital, often in the basement of the building.

★ Ask for our literature on the general subject and permit us to help you with your plans. Address your inquiries to Department of Research, American Sterilizer Company, Erie, Pa.

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When you strip old paint from metal beds, tables, chairs and other furniture before refinishing, don't do it the hard way. Because there is a practical, quick low-cost technique for handling this work on a year 'round basis.

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READER OPINION

Keeping Trustees Informed

Sirs:

We have been receiving Trustee Forum reprints for the past year and our trustees find them a source of much information they would not be able to obtain otherwise. We give copies out at each monthly board meeting. They constitute a fine means of keeping trustees informed on various problems that hospitals must meet now and in the future. We do not want to be without the reprints.

Mrs. L. S. Knuth
Superintendent
Brownsville General Hospital
Brownsville, Pa.

Return to India

Sirs:

During my three years' absence in the United States, the Mungeli hospital has been going full strength and has been growing all the time. The hospital of 60 beds was actually overflowing with 135 patients. There were patients in the rooms, on the veranda floor and under the trees. Most of them were eye cases but there was a considerable number of general medical and surgical cases. A number had come long distances.

Not having been in the hospital for three years I was amazed at the amount of work being done by such a small staff. Dr. Victor C. Rambo with his assistant and the small nursing staff has been carrying on work that would be almost impossible to do in the States under such conditions. Not only is the staff small but even the facilities at their disposal are not adequate.

The second thing I was amazed at was the spirit of service that prevails amongst the hospital people. Doctor Rambo is the moving spirit in the entire organization. Christian service and humbleness of heart are manifested in the entire organization.

Besides the work in the hospital Doctor Rambo has been touring the villages, establishing eye clinics. Two hundred twenty-three operations have been done on tour. These eye clinics are established within a radius of 80 miles. Patients assemble, he holds consultation for them and then operates in an improvised operating room.

This touring work has been quite successful, for in these last three years the sight of hundreds of people has been restored, which would have been impossible if these operating clinics were not conducted.

I wish to thank all my American friends, churches and interested people not only for making my stay in the States an educational one but also for the opportunities of broadening my vision and outlook on life. I have come back to my country with newer ideas which I hope to carry through in future, all the time keeping in mind the Christian service for humanity and hope for the lost.

With hearty salaams,

Yours, happy in His service,
P. D. Sukhnandan
Christian Hospital,
Mungeli, C. P., India

Taking English Very Hard

Sirs:

I am a young Cuban physician (30 years old) and I am interested if I could work in a hospital in the United States, and this is the motive why I am taking off some of your busy time.

I graduated in the University of Havana in 1940 and since I have been working in several towns in Cuba as a general physician, and I am very anxious to work, study and learn as much as possible in your Hospital.

I am in a good health and also taking English very hard and I suppose that in a short time I will control your language.

If there is any possibility to work in that Hospital, I will appreciate it if you write to me as soon as possible saying the conditions whatever they may be.

Literature Wanted

Sirs:

From the standpoint of literature we've reached a new low. At this point I'm sure a Sears Roebuck catalog would be a best seller, if available. If you could fix it up, I'd very much appreciate receiving The Modern Hospital. In all probability, copies wouldn't catch up with me for months, but it's about the only way I can figure of keeping up a bit with what's going on. Doctor Pye of the Brisbane General lent me his to glance over, but they weren't too recent.

Capt. John M. Stacey, M.A.C.R.
No. O-482667 Ninth General Hospital
A. P. O. 928, Unit 1
c/o Postmaster
San Francisco

Haven't We All?

Sirs:

In today's *New York Times* a paragraph reads like this:

". . . A Navy hospital . . . will be staffed by 65 doctors, four dentists, shrdlu cmfwyp . . ."

We have some of these, too!

Edgar C. Hayhow
Superintendent
Paterson General Hospital
Paterson, N. J.

SMALL HOSPITAL QUESTIONS

Conducted by Gladys Brandt, R.N., Children's Free Hospital, Louisville, Ky.; Jewell W. Thrasher, R.N., Frasier-Ellis Hospital, Dothan, Ala.; William B. Sweeney, Windham Community Memorial Hospital, Willimantic, Conn.; A. A. Aita, San Antonio Community Hospital, Upland, Calif.; William J. Donnelly, Greenwich Hospital, Greenwich, Conn., and others

Making Up Overtime

Question: Do other hospitals make up time to the surgical nurses or other nurses who are on call? Or do they consider that the extra time just goes along with the position?—E.M.D., N. Y.

ANSWER: As a general rule most hospitals make up time to nurses who are on call by giving them other time off duty.

During the present emergency, it is not always possible to do this, so that in many instances this time has been considered as part of the position.

One general rule that may be followed is that when the person is just on call and does not have to come in, no time is made up, but when it is necessary for her to come in on duty, then that time is made up.—JAMES W. STEPHAN.

Are Hospitals Liable?

Question: Our board of directors is considering whether or not malpractice insurance should be carried for our hospital. During the past it has taken the stand that charity hospitals are not liable. However, with the present trend in thought we are wondering if this is the proper attitude to take.—A.M.J., Wis.

ANSWER: Immunity of charities from suits for bodily injuries has been breaking down rapidly all over the country as one court after another examines the grounds on which these decisions rested. A recent decision that seems to demolish the immunity principle entirely where it is not too long established is found in the President and Directors of Georgetown College *v.* Hughes, in the U. S. Court of Appeals for the District of Columbia (decided June 30, 1942).

This decision reviews practically all authorities on the subject. It traces the immunity back to its origin in an erroneous decision in an English case in 1846. This was overruled in England, but the fact that it was overruled was not observed by all courts in this country. Massachusetts and Maryland began following the principle that was discredited in England and thus it spread throughout the country. Yet American courts at once began breaking down the immunity by working out exceptions.

The opinion in the Georgetown case is necessarily long and parts of it could be understood only by lawyers. However, the following excerpts will undoubtedly point out how the attitude of the six judges of the court, who were in agreement, was in favor of the plaintiff.

"Paradoxes of principle, fictional assumptions of fact and consequence, and confused results characterize judicial disposition of claims from charities. From full immunity through varied but inconsistent qualifications to general responsibility is the gamut of decision.

"On the other hand, scholarly treatment outside the courts is almost uniform. There is general agreement of such opinion in support of liability and against immunity. From this decision, and many more, it would appear that, for negligence and tortious conduct, liability is the rule and immunity is the exception.

"Generally, also, charity is no defense to tort for wrong done. It is no answer ordinarily to say, 'He did not pay and was not bound to pay for the service. I gave it to him.' One who undertakes to aid another must do so with due care. Whether the good Samaritan drives a mule or a Cadillac, or picks up a hitchhiker in a Model T, he must drive with forethought and caution. He is not relieved because it is his driver rather than himself who lapses into carelessness. Nor does it matter that the doer of good is a corporation, if the act of gratuitous service is incidental to the business. Charity suffereth long and is kind but in common law it cannot be careless. When it is, it ceases to be doing kindness and becomes actionable wrong doing."

This much, however, is sure. The immunity, so far as it ever existed, has largely disappeared as to all persons and classes of claimants save one. This includes only so-called beneficiaries of the trust or charity. That class now is disintegrating and the rights of the beneficiary who needs the protection most also are obtaining recognition.

From this welter of conflict the following general, but not too sure, conclusions may be made. Five states appear to have no decisions on the subject. Eleven apparently adhere to full immunity, with the exceptional liabilities that have been noted. Three certainly, and apparently a fourth, have imposed unqualified liability. New York has done so after tortuous efforts to find a satisfactory intermediate stopping place.

Colorado and Tennessee leave no question as to liability of the charity, while Georgia and some other states apply it to the extent of property owned by the corporation and used not directly in carrying on charitable enterprise but to produce income for its support. The trend in the states last referred to seems clearly toward unqualified responsibility. When its weight is added to that of the jurisdictions which impose full liability the apparent preponderance of authority supporting immunity disappears.

The state of Wisconsin so far, according to our study, enjoys immunity except for the failure to observe the statute requiring public buildings to be kept in a safe condition.—DON C. HAWKINS.

Courtesy From Doctors

Question: One of our doctors does not seem to understand the courtesy due a superintendent but, instead, treats her like a student nurse. What can be done in such a case? It seems hard to take such things after graduation. Is it a complex? Don't they understand or don't they care how things go? Is there a way to remedy this?—A.O'N., S. D.

ANSWER: Without more information regarding the nature of the discourtesies and the personal characteristics of both persons it is difficult to reply to this question. All co-workers should be treated courteously; there should not be one manner and tone of voice for a board member and another for a maid or porter. Those who are placed in positions of responsibility must be careful not to become authoritative in manner or demand deference. Discussion of the problem with an understanding member of the board may produce a solution of the problem.

Appealing to the physician for help with the problem or a frank discussion with him may clear the atmosphere. The psychology of approach depends upon the individuals concerned.

Every superintendent has many difficult situations with which to contend. One must remember that we are all under great strain at present. No group is more overworked and harassed than are medical men and hospital administrators and where tensions are great difficulties are magnified. A good test of the seriousness of the situation is this: "Is this harming the organization or is it merely distressing me?" If the former, something must be done; if the latter, the best plan is usually to grin and bear it.—MABEL BINNER.

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LOOKING FORWARD

Look Again, Mr. Dingell

ONE of the co-authors of the Wagner-Murray-Dingell Bill to amend and extend the Social Security Act, Representative Dingell, has made a vigorous attack upon the American Hospital Association. He states that the association is trying to raise a lobbying fund from public treasuries to oppose the medical and hospital section of his bill.

Fortunately, the charges of Representative Dingell are without foundation. It is true that one of the purposes of the increased dues is to put the financing of the Wartime Service Bureau of the A.H.A. on a sound and secure footing. But when this bureau was established it was clearly stated in the resolution which authorized it that the bureau should not engage in lobbying or political pressure of any kind.

The bureau is, as its name states, a service bureau to aid hospitals as a group in their contacts with the various administrative agencies of the federal government. It is equally a service bureau to these federal agencies in their contacts with hospitals. It affords them a quick and accessible means of obtaining information and advice and of conveying to the hospital field news about their rulings and services.

Whatever lobbying has been done by hospitals in Washington, and it has been almost negligible, has been the responsibility of the joint committee of the three hospital associations. This committee has been functioning for a decade. It is composed of hospital administrators and other representatives of the American, Catholic and Protestant hospital associations. It meets from time to time and attempts to inform legislators of the views of hospitals on particular matters.

Neither the American Hospital Association nor the joint committee have indulged in any of the cheap tricks of the usual Washington lobby. There have been no lavish dinners, no deluge of letters or telegrams, no wild and vicious attacks on political opponents. Whatever has been done has been dignified, ethical and restrained.

The major objective of the American Hospital Association in requesting increased dues has been to provide more and better services to the hospitals of the United States and Canada. The Bacon Library has been and is being improved. Full-time executives have been provided for the council on public education and the council on association development.

Studies are under way looking toward the improvement of hospital personnel practices, hospital rate systems, hospital accounting and business practices, the architectural planning of hospitals, insurance, conservation and safety programs, simplification and standardization of supplies, treatment of alcoholics, medical record practices, nursing services, radiologic service and a long list of other hospital functions. Several institutes are being planned for the education of department heads in hospitals.

It is curious that Mr. Dingell has not been aware of the wide contrast between the restrained and judicious attitude of the majority of hospital people toward his bill and the violent attacks made by the National Physicians Committee for the Extension of Medical Service whose intemperance has threatened to defeat its own ends. The American Hospital Association has carefully refrained from joining in the committee's activities.

Look again, Mr. Dingell. Don't let your enthusiasm for the bill that bears your name blind you to the solid, constructive and progressive work that American hospitals are doing.

"After War—the Deluge"

IN A recent leaflet under this title, one of the leading hospital supply houses analyzes the situation that will face hospitals upon the conclusion of war. "As we see it, peace day presents the hospitals with a double problem that might be tragic. At the very time when the public demand for 'normal' service will rise like a tidal wave, the volunteers who have faithfully plugged the holes in the dike of 'streamlined' service will vanish like the morning mist. After the war—the deluge."

Just what the postwar position of volunteers will be is, of course, uncertain. This subject should be explored carefully by all hospitals.

Whether volunteers continue or not, however, plans should be made for restablishing hospital nursing service on the proper basis. Many hospitals have been forced to cut their nursing care to a level that is far below reasonable minimum standards. Some are relying almost entirely on students and on volunteer and paid aides. The tremendous increase in the use of aides will certainly be a factor in determining the postwar pattern of hospital nursing service.

As volunteer aides disappear, will paid aides be employed? Should these aides have only five or ten hours of instruction, should they have eighty or a hundred hours as the Red Cross aides do or should they have a full year of educational preparation to become registered practical nurses working under graduate nurses?

Advances in nursing have always been influenced by advances in medicine. As the physician acquires new technics he constantly passes other technics over to nurses. In many places the shortage of physicians has accelerated this process. We may expect, therefore, that the definition of nursing will have changed rather markedly during the war years.

When our staff physicians return from service in the armed forces they may well wish further changes. Certainly, they will not remain unaffected by the group practice arrangements to which they have become accustomed.

As the nurse takes over additional duties and responsibilities from the physician, she too inevitably passes on some of her previous responsibilities to others. Large areas that once were the province of the nurse have been passed to the housekeeper and the hospital dietitian. Since the use of ward aides was expanding rapidly in the decade just before the war occurred, it seems highly probable that this trend will continue in the period immediately following the war.

Will this result in a period of great unemployment for graduate nurses? Will we again be oversupplied? It seems probable that hospitals will continue, after the war, to expand their nursing staffs and that the same will be true of public health services and of industrial medical services. Whether all of these plus matrimony will be able to absorb the large number of new nurses created by the cadet nurse corps only time will tell.

Criteria of Good Writing

WE HAVE been requested to republish the basis on which The MODERN HOSPITAL Gold Medal Award is decided. "On numerous occasions," writes our correspondent, "I have discussed the award with other hospital people. From their conversation I have gathered that the award is one of the most highly desired honors in the hospital field. Furthermore, it has been commented that it is highly desirable to have an award available to those struggling for recognition as well as to those who are recognized in hospital administration.

"I have always felt that your instructions to writers at the time the award was originally announced did more to encourage writing and to improve writing than anything I have seen. Perhaps it would not be out of place to republish those instructions."

We are happy to do so. They are as follows:

Eligible Articles.—Original articles that are published in The MODERN HOSPITAL and have not prior thereto appeared in other magazines or been presented as convention papers are eligible for consideration. Articles may range from a few paragraphs to two or three pages.

Eligible Authors.—Any person employed in a hospital or interested in some aspect of hospital work is eligible to compete. The only persons barred from an award are employes of The MODERN HOSPITAL and their families, members of the magazine's editorial board and editorial consultants.

Time.—The year for the contest commences with the July issue and ends with the following June issue.

Basis of Award.—While the judges are to exercise their own discretion in granting awards, the suggested basis of award is as follows: Intrinsic value—How much improvement in hospital service does the idea promise? How significant is this improvement? . . . Originality—Is this an entirely new idea? Is it a new synthesis of existing ideas? Is it a new and stimulating aspect of an old idea? . . . Practicality—How much time, effort and money are required to put this idea into effect? Will it involve extensive retraining of personnel? Do the benefits exceed the obstacles? . . . Wideness of application—Is the suggestion applicable to large and to small general hospitals? To mental and tuberculosis hospitals? In all parts of the United States and Canada? Will it help to improve service to all or to a substantial number of hospital patients? . . . Quality of expression—Is the thought expressed clearly, succinctly and forcefully?

Winners of gold medals to date are as follows: 1941, Capt. Lucius W. Johnson, U. S. Navy; 1942, W. B. Forster, City Hospital, Akron, Ohio, and 1943, Dr. Hugh Cabot, Needham, Mass. Honorable mention was not given in 1941. In 1942, honorable mention went to Charlotte Dowler, Doctors' Hospital, Seattle; Dr. Harry Agress, Jewish Hospital, St. Louis, and Dr. Albert W. Snoke, Strong Memorial Hospital, Rochester, N. Y. In 1943, honorable mention was awarded to Dr. Paul A. Lembcke, district health officer, Rochester, N. Y., and, for a joint article, to Dr. Catherine West, Lois Schaller and Dr. J. A. Myers, all of Minneapolis.

Postwar Bottlenecks

A TIMELY thought on postwar planning is expressed in a little booklet recently published by Eggers and Higgins, New York architects. They point out that there will be shortages of some kinds of building materials in the early months of peace and there may also be serious shortages of contractors available to perform construction. Many contractors and subcontractors have closed their shops and worked as individuals during the last two years.

If a hospital can advance its building plans to the point at which the matter can be discussed tentatively with a contractor, this may be an important hedge against serious delays, particularly in areas in which much construction will be undertaken.

Federal control over materials may continue for some period after the war so that the most vitally needed projects can be built first. Obviously, the person who has at least preliminary plans and specifications ready will be in a much better position to obtain controlled materials than one who has taken no such steps.

HEADLINE NEWS

Rationed Food Ruling on Meat-Fat Points; "Meal" Is Defined

WASHINGTON, D. C.—In addition to placing hospitals in a special classification, the Office of Price Administration has announced the method to be used by hospitals in computing their ration allotments of sugar, processed foods, meats and fats under its revised rationing program which makes a clear distinction between "meal" and "refreshment."

Rationed foods needed for meal service are based on either the amount of food used during the December 1942 base period or the number of persons served meals during that period multiplied by a maximum allowance per person.

Allotments for refreshment services are based only on the institutional user's base period use of rationed foods for refreshments.

Among several amendments to G.R.O.5 put out in late February and early March, amendment 48 took up the question of points to be collected from persons eating regularly at a hospital for seven days or longer when the 10-point food ration stamps came into use. The amendment reads:

"Operators of these establishments will collect 10 points per week for processed foods and 10 points per week for meats-fats. In the event a person takes his meals at the same place for two weeks, 30 points for meats-fats will be collected. Points will not be collected if less than eight meals in one week are taken or if a person remains at the establishment less than a week."

Would Boost Cadet Nurse Pay

Plans are under way in Washington to obtain legislation to increase the salary of senior cadet nurses serving in federal hospitals from $30 to $60 per month plus maintenance, Dr. Claude W. Munger told a meeting of the New York City Nursing Council for War Service.

Veterans Bill Is Introduced

WASHINGTON, D. C.—The American Legion's bill to provide every veteran with free hospital care and education, cheap loans to purchase homes, farms or businesses and up to 52 weeks of unemployment compensation of from $15 to $25 per week within the first two years after discharge was introduced in the Senate by Senator Clark of Missouri and 77 co-sponsors on March 13.

"Package Plan" Discussion One of High Points in Blue Cross Conference

With 67 plans represented, the winter conference of Blue Cross plans held in Detroit, March 5 to 8, was the best attended in the history of the movement. Interest was focused sharply on broad policies and principles and not on administrative details.

A keen desire to be able to offer medical and surgical plans, on either a service or an indemnity basis, was a high point of the session. All the first day was devoted to such plans. Ten Blue Cross plans reported that they hope to start medical or surgical plans before the end of 1944. All seemed to agree that the closest cooperation should exist between Blue Cross plans and medical care plans.

The cash indemnity program of the American Health Insurance Corporation was presented by Dr. Frank P. Hammond of the Plan for Hospital Care, Chicago, who stated that it is ready now and contains "no restrictions of doubt, speculation and uncertainty." This program would be available only to Blue Cross subscribers as part of a "package plan." It conforms fully, he said, to the policies of the American Medical Association.

A mutual insurance corporation to provide surgical indemnity has been formed by the New York City plan and the Cleveland plan is now forming such a corporation. Both of these organizations expect to serve wider areas than merely their present subscribers. Louis H. Pink, president of the New York plan, stated that his corporation would be glad to enroll employes of companies that have offices in New York City

(Continued on Page 44)

Army, Navy to Aid in Social Adjustment of Blinded Servicemen

WASHINGTON, D. C.—Servicemen blinded in the war will remain members of the Army, Navy or Marine Corps until they have been adjusted to take their places in society, according to an announcement of the War Department on March 4. A center where they will stay is to be established and operated by the Army Medical Department.

Col. Frederic Thorne, M.C., considered one of the Army's foremost ophthalmologists, will head the proposed center where blinded veterans will be transferred immediately after hospital treatment for acute conditions. The social adjustment program applies to all blinded veterans of this war whether or not under treatment or previously discharged from service and to blinded prisoners of war.

The broad program will be directed by Col. Augustus Thorndike, M.C., newly appointed chief of the physical reconditioning branch, Reconditioning Division of the Surgeon General's Office, and Maj. Walter E. Barton.

June Classes Necessary to Meet Student Nurse Quota

WASHINGTON, D. C.—All nursing schools were strongly urged to accept June classes of student nurses in a release sent out by the U.S.P.H.S. division of nurse education on March 14.

Advantages of a June class were listed as: (1) permits more nearly maximum use of limited teaching facilities; (2) prevents losing many of the best students to industry or other fields; (3) starts students at the height of their enthusiasm and while habits of study are strong; (4) stabilizes nursing service in the hospital; (5) offers the only opportunity by which the quota of student nurses needed for the current year can be reached. The acute need for nurses "can be met only if every school of nursing adds a June class to its program this year," the division states.

The problems of housing, limited teaching personnel, lack of adequate clinical facilities can be overcome.

File Deferment Forms Now!

Hospitals are failing to file enough applications for deferment of interns to maintain the agreed quota of junior residents, P.&A.S. announced March 23. Hospitals were strongly urged to: (1) determine exact dates on which all commissioned officers will complete internships; (2) file Forms 218-Revised for one third of them (even if the particular hospital does not need them, since other hospitals do) at least four months prior to this date; (3) send these data to state P.&A. within 30 days.

"Package Plan" Featured at Blue Cross Conference

(Continued From Page 43)

wherever those employes may live and work.

The proposal of the American Health Insurance Corporation was violently attacked by John A. MacNamara of the Cleveland plan.

The Hospital Service Plan Commission recommended that the provision of hospital and medical service through prepayment plans should be achieved only on a nonprofit basis and that it is not in the public interest for a Blue Cross plan to serve as an agent for a commercial organization.

The committee on "package plans," headed by J. Albert Durgom of the New Jersey plan, reported that of the 12 plans now offering surgical coverage the majority are willing to cooperate with employers and commercial insurance companies in offering a package plan. They would present combined literature, combined subscription rates and joint billing.

Of the plans not offering a surgical coverage, the majority also indicated willingness to cooperate. "There is no doubt of the practical value of cooperating with well-established group companies," the committee stated. "The package plan does not place a Blue Cross plan in competition but rather in coordination with the health program of the employer."

Other important developments at the conference included:

1. The plans directed their public relations committee to draw up a proposal for a national advertising campaign and to present it at the fall conference. The plans voted overwhelmingly in favor of using paid advertising to supplement present public educational efforts, even to the extent of contributing from ½ to 1 per cent of total income for this purpose. This action was taken after presentation of a comprehensive market analysis of Blue Cross plans by Anson C. Lowitz, vice president, J. Walter Thompson Company, New York City.

2. The plans were challenged by Dr. Sidney R. Garfield, medical director of Henry J. Kaiser's industries, to broaden their concept so that they obtain the efficiency of group practice and make sure that facilities are adequate to meet present day demands of medical service.

3. Increased emphasis on preventive medicine and on good diagnostic services at modest cost was urged by Mr. Pink who said that "without preventive medicine, we shall fail. It must be part of any broad scheme."

4. The plans approved by more than a 3 to 1 vote the proposed study of their operations by the U. S. Public Health Service and urged all plans to present the matter to their trustees and report to the commission office by April 10 whether they will cooperate. Opposition to this study was voiced by Mr. MacNamara and Abraham Oseroff of the Pittsburgh plan.

5. They voted to amend their administrative regulations so that each year one member of the Hospital Service Plan Commission shall be elected on nomination by the president of the A.H.A. Thus three of the commission's nine members will be nominees of A.H.A. presidents. This appeared to make unnecessary the Cleveland Hospital Council's recommendation for a separate and duplicating commission composed exclusively of hospital administrators.

6. Much more emphasis is to be placed on the enrollment of farmers, residents of small towns and persons now excluded by enrollment restrictions.

7. The Connecticut plan presented a program for giving Blue Cross protection to unemployed subscribers at one half the usual cost for a six months' period.

8. The Cincinnati plan reported a successful experience with the organization of subscribers' councils to give subscribers an actual voice in plan operation.

9. The commission reported that it was holding its fire on the Wagner-Murray-Dingell Bill in the belief that Congress is not now in the mood to pass this legislation and that the temper of the people is changing.

10. Fifty-two of 57 reporting plans stated that some employers now contribute some part of the subscription payment, many of them paying 50 per cent. Most of the plans are in favor of employer contributions.

11. Frank J. Walter, A.H.A. president, called on Representative Dingell and other "individuals holding public office to be careful not to make statements without checking on their accuracy." He said that the A.H.A. has never had and does not contemplate a paid lobby against the Wagner-Murray-Dingell Bill, as charged by Mr. Dingell. He also announced that Doctors West, Fishbein and Irons had been appointed by the A.M.A. and Doctor Buerki and Messrs. Bugbee and Hamilton by the A.H.A. to work on the relationships of radiologists, pathologists and anesthetists to hospitals.

12. Improved reciprocity agreements were outlined and will be sent to all plans.

13. More than enough financial support to start a national enrollment office was pledged by the plan directors.

14. Enrollment goals for 1944 have been set by the plans themselves and most of these are higher than the goals set last year by the approval committee.

15. Six regional enrollment conferences have been planned for the coming year.

16. An award was presented to the Cleveland plan as the first plan to enroll more than 50 per cent of the people in its territory.

Doctor Hoge Assigned to Task of Relocating Doctors, Dentists

WASHINGTON, D. C.—Dr. Vane M. Hoge, recently made senior surgeon, chief of the hospital facilities section, State Relations Division, U. S. Public Health Service, has been placed in charge of the relocation of private practicing physicians and dentists, it was learned in an interview March 9.

The sum of $200,000 for the fiscal year ending June 30, 1944, is to be used for this relocation. Any municipality, county or other local subdivision of government may file an application to secure a physician or dentist. Upon receipt of the community's application and payment of $300, the Public Health Service can enter into an agreement with a physician or dentist who has a permit to practice in the state in which the applicant community is located, who agrees to practice in that community for at least a year and who is acceptable to the community.

Of the total cost of transportation of the physician or dentist, his family and his household effects and the relocation allowance, 75 per cent is contributed by the U. S. Public Health Service and 25 per cent, by the community in which the doctor is relocated.

A.H.A. CHANGES MEETING PLACE

Change in the convention city from Chicago to Cleveland has been announced by the American Hospital Association. Meeting dates will be October 2 to 6, and the convention will be housed in both the Statler and Cleveland hotels.

House Approves Lanham Act Funds

WASHINGTON, D. C.—A bill to provide $120,000,000 of additional funds to the Federal Works Agency to continue operations under the Lanham Act has passed the House of Representatives but is awaiting action by the Senate as this section goes to press. Previous Lanham Act appropriations have been practically exhausted.

F.W.A. Approves Aid to D. C. Hospitals for Nurse Training and Housing

By EVA ADAMS CROSS
Washington Representative, The MODERN HOSPITAL

WASHINGTON, D. C.—Although virtually all the funds appropriated under the Lanham Act for community facilities elsewhere have been allocated, there is still a balance of funds in the appropriation that Congress made specifically for projects in the Washington metropolitan area, Maj. Gen. Philip B. Fleming, F.W.A. administrator, announced January 29.

The recently completed Suburban Hospital, Bethesda, Md., is slated for additional federal assistance for its maintenance and operation. The new action provides for an increase of $55,141 in a previous federal contribution, from $68,850 to $123,991, and for extension of the period of assistance one year from Dec. 31, 1943.

Children's Hospital will get a grant and loan of $143,000 from F.W.A. for nurses' home and training facilities. An additional wing will be constructed and equipped to house approximately 70 student nurses. Alterations will be made on an existing kitchen and orthopedic department.

To Providence Hospital goes approval for a $181,465 increase, from $63,235 to $244,700, for a nurses' home and training facilities.

F.W.A. has approved for Georgetown University Hospital a nurses' home to house approximately 50 students. Furnishings and equipment are also provided for in the allotment. The building will cost $84,000, the furnishings and equipment, $9000.

A project approved for Garfield Hospital will provide for the construction of a building to house some 66 student nurses and additional training facilities; alterations to the existing kitchen and dining room facilities, and for furnishings and equipment. F.W.A. will provide a grant of $70,000; Garfield will furnish $40,000.

Maternity Care Given to 200,000

WASHINGTON, D. C.—Nearly 200,000 babies and their mothers had been cared for up to February 1 under the Emergency Maternity and Infant Care program, according to an announcement on March 5 by Katherine F. Lenroot, chief of the Children's Bureau. Throughout the United States, and in Hawaii, Alaska and Puerto Rico, which has just been added to the list, the program is now in operation or about to be put in operation.

Priority Assistance Procedures Are Simplified; One Form Replaces 20

WASHINGTON, D. C.—A new and greatly simplified procedure for hospitals and other organizations applying for priority assistance was announced on March 8 by Arthur G. Eaton, recently appointed director of the Government Division of W.P.B.

A revised standardized form, WPB 1319, has been adopted to replace 20 different forms which covered 52 separate items of equipment. It is expected that in the future this form may be used in place of still other forms thus further reducing the number of forms and the amount of paper work involved.

"It is to the distinct advantage of the applicant to begin immediately to insert in Block 6 of this form the words 'Government Division'," Mr. Eaton stated. "Applications so identified will be sent promptly to the division for processing."

A single form can be used for any number of items of equipment that are controlled by a single W.P.B. order. Separate forms are to be used if the items applied for are controlled by different W.P.B. orders or divisions or if more than one supplier is to be shown on the application.

Preference ratings can be assigned on WPB-1319.

The orders now requiring use of this new form which are of interest to hospitals are: L-13-a, metal office and industrial furniture and fixtures; L-18-c, new domestic vacuum cleaners; L-23-b, new domestic electric ranges; L-28, incandescent, fluorescent and other glow discharge lamps; L-39, signal and alarm equipment and air-raid warning devices; L-65, new electrical appliances and electric resistance materials; L-74, oil burners; L-75, coal stokers; L-79, new plumbing and heating equipment; L-98, domestic sewing machines; L-112, new and used industrial power trucks.

L-140-a, cutlery; L-140-b, flatware and hollow ware; L-144, new laboratory equipment; L-176, domestic and commercial electric fans; L-182, new commercial cooking and food and plate warming equipment; L-215, new industrial sewing machines; L-222, new floor finishing and maintenance machinery, rug cleaning machinery and new industrial vacuum cleaners; L-248, commercial dishwashers; L-266, sterilizing equipment, and L-267, new photographic equipment and accessories.

New O.C.D. Chief Says Medical Services Will Be Maintained

WASHINGTON, D. C.—Dr. W. Palmer Dearing, senior surgeon, U. S. Public Health Service, who succeeded Dr. George Baehr on March 1 as chief medical officer of O.C.D., declared in a recent statement that the program and policies of the medical division, as developed in the last two and a half years, will continue unchanged.

The emergency medical service, the casualty receiving and emergency base hospitals, the plans for emergency medical service to industrial plants, and the plans for mutual aid on a state-wide or regional basis for distribution in an emergency of personnel, equipment and supplies, including blood plasma, must be maintained, he said.

Dr. Courtney M. Smith, senior surgeon, U. S. Public Health Service, formerly regional medical officer of the Ninth Civilian Defense Region, will become assistant chief medical officer.

New Surgical Truck Permits 80 to 100 Operations per Day

WASHINGTON, D. C.—A new type of surgical operating truck for the Army has been devised that enables several surgical teams at the front lines to work at the same time with the result that from 80 to 100 men can be operated on during a full twenty-four hours. In the old type of surgical mobile unit only one team can work at a time. The idea for the new truck was conceived by Surgeon General Kirk.

The six wheeled truck has a 2½ ton capacity. The teams work in tents attached to the rear of the truck. The tent rooms are double-walled and lined in white duck to give light. Screened windows give added illumination. The inside of the truck is used for storage of supplies, instrument cabinets and scrub sinks. Numerous units have already been sent overseas.

Out for a Campaign!

Some Suggestions on Capital Fund Raising

as told to
RAYMOND P. SLOAN
by
JAMES B. SLIMMON and BARCLAY ROBINSON
Hartford Hospital, Hartford, Conn.

EVERYONE is familiar with the whirlwind fund-raising campaign that strikes town practically overnight with its bombardment of rallies, press releases and radio talks. For a brief span of weeks it runs its turbulent course until, having gained its approximate goal, it departs as suddenly as it came, leaving the average citizen bewildered about everything, including his own financial status.

In contemplating a campaign to raise a building fund of $5,000,000 for the Hartford Hospital, Hartford, Conn., such procedure was deliberately avoided. A campaign for capital funds should comprise three distinct phases, it was agreed: first, its preparation; second, the campaign proper, and third, its follow-through. Without careful attention to these three steps no campaign can hope to attain its full potentialities.

Experience proved the truth of this argument. The Hartford campaign was months in preparation, its actual conduct consumed a year, its follow-through is still in process and will continue indefinitely. Having gone over the top the fund is still mounting.

Time and persistence are required in telling the hospital story, particularly when seeking gifts as memorials. If at first you don't succeed, try, try again. It is the only way by which $30,000 can be transformed into $300,000. No trick of magic is involved, just plain determination, also thorough case studies of each promising prospect. But more about that later.

Another conclusion was reached in Hartford that might well apply to other communities contemplating a campaign. Professional assistance is essential. Any hospital board that thinks otherwise is fooling only itself. It hasn't the organization to formulate the program or the ability to present the story properly. It needs the benefit of other experiences, methods employed and results obtained in different communities.

Professional assistance is necessary, too, to obtain the required leadership. For where can a qualified leader be found who will assume responsibility for a campaign without the assurance of adequate support?

Essential attributes for leadership are vision, interest, conviction, personality, diplomacy and determination. The leader must also have the necessary time to give to the work.

Such diverse qualifications are seldom centered in one individual. When obtainable, therefore, he should be given full responsibility and the freedom to go ahead and act. He can permit no interference from individuals or groups with conflicting ideas. The setup may be compared to a well-organized army with full authority specifically delegated.

Too many and too large committees can become unwieldy, particularly in the solicitation of memorial gifts. Matters of a personal nature are oftentimes discussed more freely in smaller groups. Hartford's memorial gifts committee, originally comprising 40 members, resolved itself into a group of 20 whose efforts produced $2,585,840, or more than half the goal.

Flexibility in the selection of chairmen and committee members is important. These need not necessarily be hospital trustees. Any citizen possessing the interest, the time and the willingness should be enrolled. His performance may be so outstanding that eventually he will earn a place for himself on the hospital board, thus substantially strengthening that group.

The Public Must Be Convinced

The success of a campaign is measured by the care that is taken in its preparation. To sell any product successfully, you must know something about it. How is the hospital regarded by the community? Is its appeal for funds based on an intelligent survey of existing health needs? The time has passed when the public will fall for any cock-and-bull story. Today, it must be convinced. There must be definite reasons for making the appeal and these reasons must be skillfully presented.

This is another reason why professional counsel is important. Its workers, by virtue of long experience in public relations, are masters of the process of testing public opinion. Before the Hartford campaign started more than 10,000 questionnaires were mailed to residents asking their opinions of the institution. The framing of such a questionnaire is in itself an art. This mailing drew a 21 per cent return, which according to an executive of one of the city's large industrial organizations "is far better than we ever get."

The same skill that is applied to questionnaires goes into planning illustrated brochures and other mailing pieces, into getting articles written in good journalistic style appearing in the local press, into arranging meetings, dinners and luncheons, into making notes on conferences, into handling the countless details that are so essential.

A citizens' committee to sponsor the entire program was one of the important preliminary steps taken in Hartford. The presence among this group of trustees of other hospitals attests to the community spirit that was manifested. This led to a precampaign dinner to which members were invited.

Such an occasion provides an opportunity for revealing plans and gaining public support. The guests were informed that sooner or later they would be approached for a gift to the hospital and that in the meanwhile there were certain facts they should know. Of approximately 400 who were invited, 375 attended. This surprising showing may be attributed to the interest aroused by the preliminary program of public education.

The campaign which was worked out in Hartford and which undoubtedly will find parallel in other communities was divided into three parts: first, memorial gifts; second, industrial subscriptions; third, contributions by the general public. It was recognized at the start that the major portion of the sum of $5,000,000 would have to come from the first two. The public campaign, therefore, was reserved for the last.

Memorial gifts are obtained most successfully by use of a plan, particularly when that plan is part of an attractive brochure that tells the complete story. Committee members had definite suggestions to offer to each individual on whom they called. "Mrs. Jones would be interested undoubtedly in establishing a children's department or possibly a laboratory. Very well then, what about this block of private rooms? No, that entire corner indicated by green crayon has been taken by Mrs. Smith. Here is a similar layout on another floor, however."

Such an approach requires not one call but several spread over weeks, months even. If the response to the initial contact is disappointing there is time to report back to the committee for consultation. During such conferences some other member may have a suggestion for a new approach. It may be decided even to place the assignment in other hands.

As the plans become blocked in color indicating substantial financial support, interest grows. Armed with specific suggestions and skillfully assembled facts on tax laws as affecting inheritances and gifts, the hospital representative becomes surer of his ground, more confident of his results. Original gifts are doubled, trebled sometimes. Securities start changing hands. Nothing succeeds like success. Nothing contributes to failure more surely than uncertainty, fear, discouragement.

Industrial Firms Approached

Heads of Hartford's industries were similarly approached. Another group of citizens, not too large to be unwieldy and headed by a capable chairman, assumed responsibility for this second phase of the drive. These individuals were carefully coached in their presentation and provided with a formula indicating what each organization should give in proportion to the amount of service rendered by the hospital to its employe group.

In all, 150 subscriptions were received from Hartford's industrial companies, insurance companies, banks and other corporations, 75 per cent giving the full amount suggested as their subscription. The total sum thus contributed was $2,087,649.

The final stage of the campaign was devoted to subscriptions from the general public. Three weeks were designated for this purpose. It should be recognized, however, that by this time the hospital story had been well publicized through the medium of the local press and liberal mailings.

An army of some 5000 workers was enlisted, most of whom never had worked in other campaigns or community chest drives. Consequently, they had no preconceived ideas of soliciting procedures. Thorough canvassing was made of individuals living within the city limits, as well as those in the surrounding towns that the hospital serves. In this effort the large group of hospital

volunteers was particularly helpful.

The result was the sum of $523,-264.66, including special gifts below the memorial gifts' minimum, and individual pledges and gifts from employes of industrial organizations, banks, insurance companies and the hospital itself. This brought the total to $5,171,712.

Too frequently overlooked in fund-raising campaigns is the importance of the follow-through. It is not enough that the interest and enthusiasm of the public be aroused. They must be maintained and close contacts must be continued with individuals of wealth, trust officers and lawyers.

It is highly recommended, therefore, that some provision be made for this work through retaining the services of the fund-raising organization, the appointment of a special citizens' committee for the purpose or, better yet, a combination of the two. In Hartford, professional counsel is being retained and already two large bequests made in favor of the hospital will ultimately raise the total considerably.

In the meanwhile, a public relations committee of seven is being formed, most of whom played an important rôle in the campaign. They will continue contact with people who are able to make substantial gifts and supply helpful information to lawyers and trust officers and keep the needs of the hospital before the community.

Within this group is a doctor, a general practitioner, who is expected to be of great assistance in interpreting relationships between the institution and its patients. Similar assistance is expected from a sales executive whose studies of the contacts between the public and the hospital should be revealing.

It will be noted that membership on this committee is not confined to board members. As was true with the campaign, the purpose is to select the best possible man for the specific responsibility, irrespective of whether he is identified directly with the institution.

Other changes are also taking place as part of the follow-through program. In process of formation is an association of hospital friends and supporters, membership in which will undoubtedly run up into thousands before many months have passed. Voluntary contributions will be sought as membership dues. This group will include present incorporators of the Hartford Hospital.

So it becomes evident that a fund-raising campaign properly conducted holds far more significance than its name suggests. It can have a definite effect upon the entire pattern of the hospital organization. Through preliminary surveys it reveals the true situation; through conduct of the campaign proper it provides the necessary funds to remedy existing defects and provide for future expansion, and by its follow-through it assures public support over the years on a sound economic basis. It is or should be a tri-part project no phase of which can afford to be stressed to the sacrifice of any other.

Beware of Aniline Dye

A RECENT outbreak of aniline dye poisoning in the nursery of one of the major hospitals in the country again focuses attention on this hazard which has been too little emphasized.

Briefly, the series of events that unfolded the episode is as follows:

In a new-born nursery in which there were 42 infants a member of the nursing staff noticed, at 2:30 p.m., that two had become cyanotic. The house officer, who was notified, was not particularly alarmed at the time but ordered oxygen administered in small quantities as needed. At 4 p.m., four babies had developed cyanosis and at 6 p.m. six were afflicted.

At this time the staff doctor in charge of the nursery and the hospital administrator were notified. Finding six infants cyanotic and noting that all were bottle fed, the department of laboratories was asked to analyze samples of all formulas on hand.

A recent pollution of the city water supply by distillate was at first thought to be responsible. All formulas were ordered destroyed. Members of the pediatric and obstetrical staffs were notified. At 7 p.m. 12 infants had developed symptoms and at 8 p.m. the total had reached 18.

At this time it was noted that two infants, less than twelve hours old, who had received nothing by mouth, had developed symptoms. Most of the infants were by this time experiencing rather severe respiratory difficulties, in addition to the cyanosis.

It was then recalled by one of the nursing staff that a rush order had been put in for diapers during the morning and that these had come up stamped with ink, in letters approximately 2 inches high, and because of the rush they had not been laundered.

One of the staff members recalled a similar occurrence in Cincinnati in 1933. Dr. J. W. Greenbaum of that city was called by phone and immediately confirmed the tentative diagnosis of aniline dye poisoning and suggested therapy. This was instituted immediately; it consisted of blood transfusions, intravenous glucose, oxygen and, in some cases, methylene blue by vein.

By midnight of the same day all patients involved, with the exception of three, were well on the way to recovery.

Of these three infants, one showed marked inflammation of the liver and spleen for about one week, with methemoglobin in the urine, but recovered. One child died twenty-four hours later. This baby was a premature and necropsy revealed a massive intracranial hemorrhage caused by birth injury. The third baby died forty-eight hours after exposure and necropsy revealed acute peritonitis, splenitis and hepatitis.

The ink used in this case is one of the standard brands, chemically composed of a suspension of the dye nigrosin in aniline oil. Such a formula is rendered entirely harmless by heat but can be absorbed through the skin unless it is heat treated. In several reported cases it has been known to cause shoe dye poisoning as well as poisoning from the inking of crib pads and diapers.

It was felt that such an occurrence should be called to the attention of the hospital field in order that all administrators might take appropriate precautions against a similar occurrence in their own hospitals.—A. J. HOCKETT, M.D., *director, King County Hospital System, Seattle.*

The Governor Proposes

state compulsory hospital insurance through the medium of voluntary plans

THE total cost of adequate modern hospital care is not too great for the American people to bear collectively. In fact, we can, and probably should, pay more for better hospital care. Healthy working men and women can well afford the cost.

The problem lies in the fact that at present most people must pay the cost when they are sick and their earnings have ceased. Consequently, for most of us, the possibility of a major illness involving heavy hospital expense does constitute a major threat to our security.

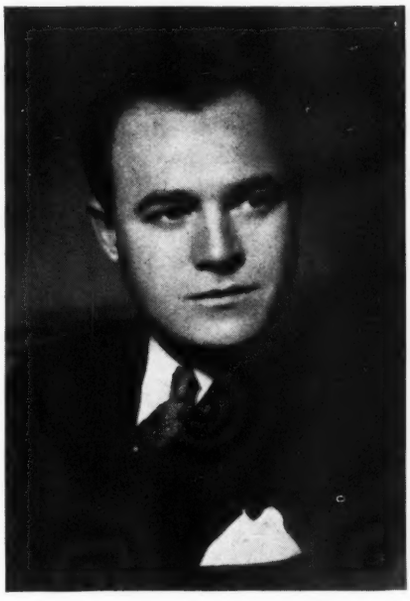
These facts are so obvious that they have led many people to support the federal hospital insurance features of the Wagner-Murray-Dingell Bill now pending in Congress. Hospitals and the medical profession would perhaps now be supporting this federal legislation if it were not for one basic fact. If the time comes when voluntary hospitals receive their major income from a governmental fund, the agency administering that fund will in fact, and of necessity, have something to say as to how these hospitals shall be run.

Major Objectives Can Be Gained

It is my belief that it is possible to accomplish some of the major objectives of the Wagner-Murray-Dingell Bill on a basis that does not involve federal control and with a minimum of state participation. I believe that existing voluntary hospital insurance plans have given a demonstration of a means by which this can be done through the utilization of existing facilities that have the confidence of hospital authorities and the medical profession.

I recommended the establishment of such a plan in my message to the Rhode Island legislature on January 4 in which my argument was as follows:

Perhaps this great country would not yet have embarked upon a broad program of social legislation if the initiative were not taken by the federal government in the depths of the depression. For that initiative and for all the good that it has produced, we are mindful and grateful, as we have been cooperative.



J. HOWARD McGRATH
Governor of Rhode Island
Providence, R. I.

We believe, however, that many of these programs could be operated better by the states where the details of the system could be integrated efficiently to the economy and needs of local conditions. We must begin to think ahead of the federal government with respect to future social security programs or stop talking about state's rights.

Apropos of this belief, I have tried to stimulate thinking and study and cooperation in Rhode Island, to the end that we might organize our own programs. I asked the department of social welfare some months ago to give serious consideration to a program that would better secure the health of our people so that we could get away from one of the great causes that lead people eventually to public assistance rolls.

By these studies, which are continuing, we conclude that serious illness in a family resulting in heavy hospital costs is one of the major threats to the security and economic well-being of the people.

Sickness Insurance Helps

The far-seeing wisdom of the legislature in establishing a cash sickness insurance law for Rhode Island only partially meets this threat. Cash sickness insurance gives the worker absent from employment through illness compensation for the loss of wages, but out of that compensation he must meet the continuing cost of living.

Here again, Rhode Island did not wait for the federal government to take the initiative and her action underscored our belief that along with the principle of state's rights goes the burden of state responsibility to meet these social problems.

Leaders in the field of medicine and hospitalization, persons interested in hospital insurance and many other civic-minded citizens have taken part in our inquiries with respect to the question of adequate hospitalization at minimum costs for our citizens. The study was commenced and proceeds upon the broad principles which I hope may be the foundation of future social security programs. I might outline those principles broadly as follows:

1. Utilization of existing facilities wherever possible, always avoiding the expense incident to the creation of new and duplicating facilities.
2. Compliance with the principles and practices of the professions or institutions to be affected by a proffered program.
3. Coverage in any program devised for as many people as can possibly be included.
4. Encouragement of the partici-

pants in a program which usually means industry and the worker to assume and share together financial responsibility for a program with a minimum state participation.

5. Avoidance of federal or state domination and control of programs and the utilization of the organization and facilities of the institutions most affected by the program.

We have proceeded on the assumption that governmental encouragement and sympathy for a program need not imply all-out governmental administrative control. With these thoughts in mind I have asked those who have been studying a program of general hospitalization insurance to present an outline of a workable program that the legislature might consider for adoption, one that would assure hospitalization to every employed worker and his immediate dependents.

Such hospitalization should include meals and dietary service, general nursing care, operating room as needed, ordinary medicines and dressings, laboratory examinations, oxygen and serum, physical therapy, maternity care, emergency care and mental and tuberculosis care.

These services could be provided on an employer-employe contributing basis. A simplified quarterly contribution of fixed amounts would avoid difficulties now experienced in plans based upon percentage deductions each week. They can be had through the Blue Cross or any other authorized insurance company that is willing to insure for these minimum benefits and for a stated number of days.

It is our belief based upon present studies that this assurance of hospitalization to himself and his dependents could be had for perhaps less than 5 cents per employed person per day.

I am sure we must agree that if such benefits could be provided at this small cost great dividends would be returned in the health of our people, in their economic usefulness to industry and in a lessening of the causes that I have said lead to permanent disability and public dependency.

Hospital facilities at the present time are filled to capacity. It is obvious that additional facilities are needed. I have talked with some representatives of voluntary Rhode Island hospitals and have been encouraged by their response. I believe that if the hospitals of Rhode Island had the assurance that every patient requiring their services was an insured patient, they would be only too willing to expand their facilities to meet our requirements.

It is not the original outlay for facilities that concerns the hospitals, but rather the ability of its patients

And the opinions vary

LEVERETT SALTONSTALL
Governor of Massachusetts
Boston

"As the health of our citizens is one of our country's greatest assets, so we are beginning to recognize as a public responsibility that an ill person should not bear an excessive burden. I agree with Governor McGrath that a practicable program which will utilize to the full all private or semi-public resources and at the same time avoid the very real dangers of governmental control, federal or state, is of great value to the general welfare of our individual citizens and to the happiness and contentedness of our communities."

RUTH TAYLOR
Commissioner
Westchester Department of Public Welfare
Valhalla, N. Y.

"The subject matter of the article is, of course, intensely interesting but unfortunately the subject is so very complex and feelings on the whole matter run so high that I do not feel it possible to comment on a specific proposal without a great deal of study. Before I could discuss Governor McGrath's article, I would be obliged to get a copy of the bill he proposes and to study it very carefully."

J. MELVILLE BROUGHTON
Governor of North Carolina
Raleigh, N. C.

"I have read this article with the greatest interest."

FRANK J. WALTER
President
American Hospital Association

"It is timely for The Modern Hospital to carry such a symposium as this. We do not know whether the Rhode Island plan is an answer to our problems and will provide the best hospital care to the American people but we must continually search and scrutinize every idea presented to us if we are to be progressive. I am sure the plan of hospitalization in the future will require a progressive step forward. I am not sure what it will be but we must be on the lookout for it."

REV. A. M. SCHWITALLA, S.J.
President
Catholic Hospital Association

"The partnership between the voluntary agencies and government agencies in health care must be progressively emphasized, particularly through legislative enactments, provided, however, that that partnership be viewed as a true partnership and not merely as a cooperative effort in which the government has the dominant rôle.

"The principle of prepayment against the costs of eventual illness must be accepted and plans must be developed to encourage each individual through such prepayment to make preparation against the hazards of illness. Prepayment insurance systems on a voluntary basis providing income for the various contingencies arising out of illness cannot but merit the support of every thinking person.

"It would not be contrary to Catholic thinking to encourage a government mandate requiring wage earners to provide for themselves and their dependents through some form of insurance and such provision

to contribute to maintenance costs after construction is complete. A compulsory hospitalization insurance law would give to Rhode Island hospitals a measure of financial stability they have never before enjoyed.

The date of actual operation of such a plan would depend upon the time when such increased facilities would be available. The hospitals cannot begin to plan these facilities until they have the assurance that they can at least be made self-supporting.

I believe the passage of a compulsory hospitalization insurance law of this type at this session of the legislature would give that assurance and that the construction work that would be induced thereby would be a great boon to the business of the state in the immediate postwar period.

If the state, our voluntary hospitals and the medical profession (and in this respect let me say that the medical profession alone should be the judge of the need of a person for hospitalization) join with labor and with industry in exercising vision, energy and determination to achieve the broad purpose of such a program and attempt to reach a satisfactory formula for effecting it we shall eliminate the need for or the dangers of a federal program in this field.

The response to the foregoing has been most gratifying. Leaders in the medical field have expressed enthusiastic approval. The Rhode Island State Medical Society is creating a representative health council to work on the development of such a plan and to study the possible extension of the plan into the broader field of medical and surgical care.

My statement has been unanimously endorsed by the board of directors of the Hospital Service Corporation of Rhode Island, the Blue Cross. It has warm support among hospital authorities. It has been endorsed by labor leaders and by some of the leading employers of the state.

Press comments to date have been entirely favorable and the plan seems to have support among the leaders of both political parties. National authorities in the hospital, medical and health fields have expressed interest.

The Wagner-Murray-Dingell Bill presents a challenge. This challenge will not be met by blind obstructionism. It is stupid to try to meet it by mere name calling of the many sincere people who believe in it. There is a basic problem that can and must be met, and it will not be met by denying that it exists.

In my message to the legislature, I stated that states must meet their obligations or stop talking about states' rights. The same advice could perhaps be given appropriately to hospitals and the medical profession.

Caution is the keynote

might even be made a necessary condition of employment. But the method of that insurance should still remain the free choice of the wage earner who makes the payment.

"The Catholic attitude toward government views government as the servant of society permitting the individual citizen the fullest degree of self-realization consistent with the rights of others and protecting the individual in instances of conflict among individuals. In Catholic thinking, therefore, the measure of the government's effectiveness will necessarily be the extent to which the individual can maintain his liberties and his rights within the necessary restrictions of governmental statute of law. . . . In Catholic thinking the government should have a minimal rather than a maximal effect." (Comment selected from "A National Health Program and the Wagner-Murray-Dingell Bill.")

R. C. BUERKI, M.D.

Dean, Graduate School of Medicine
University of Pennsylvania

"The Honorable J. Howard McGrath is to be congratulated on the clarity of presentation of his proposal for a most unique and interesting piece of legislation. He has translated talk into a concrete proposal for action. It would be my personal hope that the legislature of Rhode Island would approve this proposal in order that its effects may be studied by all groups interested in this vital problem."

ARTHUR J. ALTMEYER

Chairman
Social Security Board
Washington, D. C.

"Agreement on principles—those suggested by Governor McGrath or a more extensive series—is the first step. The large problem then remaining is to reach agreement as to how the principles are to be put effectively to work. It will be of great interest to see how this problem is met in Rhode Island. I was much interested in Governor McGrath's comment: 'In my message to the legislature, I stated that states must meet their obligations or stop talking about states' rights. The same advice could perhaps be given appropriately to hospitals and the medical profession.' "

MICHAEL M. DAVIS

Chairman
Committee on Research
in Medical Economics

"I am glad to have a governor of any state make almost any positive proposal. In general, Governor McGrath's proposition seems to be a progressive one but any man's views of such legislation will depend on what the bill contains. What wage earners and other employed persons, for instance, will be included? What income or occupational groups will be excluded? Will self-employed persons be included?

"Will the hospitalization tax which the people will pay be a flat amount for everyone or will it be a percentage of earnings? A flat amount, alike for all, would be high for the low income groups, especially if families are covered.

"The governor makes clear that the Blue Cross plans would be recognized, but how? Would the actual administration of the system be

turned over to them? If so, what provisions would be made for public supervision or public participation in the management of the plan? Or would the law be so worded that people who choose to join the Blue Cross plan will not have to pay the hospitalization tax?

"If this procedure were adopted, who would keep track of the choices and changes which people will make between the governmental and the Blue Cross plan? Will the employer do this or the state? If the state does it, the employer will have to be notified of each change. Should a worker move from one employer to another, the worker's past payment record would have to be checked up in order to establish his status from the standpoint of the hospitalization tax.

"Would it be legal, or politically practicable, to give the Blue Cross plan an exclusive place? What about the insurance companies? What about hospitalization plans which industrial or fraternal bodies may have in Rhode Island for their own employes or members?

"If these various competing voluntary plans are recognized along with the Blue Cross plan and a general state plan, the complications and the cost of acquiring, retaining and keeping track of members will become still greater."

WILLIAM H. WILLS

Governor of Vermont
Montpelier, Vt.

"I have not yet had an opportunity to study this carefully but will do so in the near future."

CLAUDE W. MUNGER, M.D.

Director
St. Luke's Hospital
New York City

"I find the plan of hospitalization insurance which Governor McGrath is advocating for Rhode Island to be very interesting. In my opinion, it is pregnant with possibilities for helping people to meet the costs of illness. I quite agree that action of this sort, in the various states, would tend to obviate the necessity, if indeed such necessity exists, for the passage of Title IX of the Wagner-Murray-Dingell Bill. I believe Governor McGrath's plan will gain the interest of the hospital profession and that, individually and in our associations, we should give it the most careful thought."

R. H. BISHOP JR., M.D.

Director, University Hospitals
Cleveland

"Governor McGrath is to be commended for his interest in attempting to meet the health needs of the employed workers and their families in the state of Rhode Island.

"1. The first question that arises is how practical it will be in meeting the needs of the situation and how effectively it can be administered. A similar suggestion was made to the Social Security Board in 1941 when the whole question of compulsory hospitalization and medical care was first raised. We were told by the administrative officers of the Social Security Board that such a program would be impossible to administrate.

"2. Great confusion would arise in determining the status of the employed worker as to whether he was insured under the state plan, the Blue Cross or a commercial insurance company.

"3. Whereas in the beginning the political domination of the program would be reduced, theoretically at least, to a minimum, still the influence would be there and would of necessity grow and increase in strength and power as time went on.

"4. If the other states followed the example of Rhode Island we would eventually have 48 modified Wagner bills and there would be no uniformity from a national standpoint. Such a proposal might have something more to commend it if there were federal legislation setting minimum standards that would have to be met by the states in adopting this type of legislation.

"5. It seems to me that Governor McGrath is overly optimistic when he indicates that voluntary hospitals can undertake with safety large capital expenditures in providing new hospitals and additions to existing hospitals on the strength of being guaranteed that the vast majority of their patients will be able to pay the operating cost of these institutions.

"The large voluntary contributions that have made such expansion possible in the past will not be so readily available in the future and hospitals will be forced to finance such capital outlays through earnings. This means that some system must be devised whereby recipients of hospital care will be paying more than the actual immediate cost of such care. Blue Cross plans make it possible to meet this situation at a minimum of cost to the individual.

"It is questionable whether a state-operated fund would make this provision or whether voluntary hospitals should seek to obtain depreciation charges from a state fund. A commercial insurance company can operate only upon an indemnity basis which, we know from experience, barely covers the cost.

"Failure on the part of the voluntary system to provide the necessary additional capital outlay would result in the use of public funds to provide the necessary facilities to meet the constantly increasing public demand for hospitalization. This was felt to be a decided objection to the federal program as outlined in the Wagner bill and would constitute, even on a state basis, a threat to the security of the voluntary institutions.

"6. Any program of hospitalization that will continue to be acceptable and satisfactory to our people must eventually carry with it a more adequate medical care program organized along similar lines. Such a combined program is entirely possible of development under the voluntary system. Compulsory legislation, whether on a national or state basis, will interfere with the full development of such a program on a voluntary basis and encourage dependency instead of self help.

"7. Further discussion of any type of compulsory hospitalization system should be discouraged and all the time and energy of the voluntary agencies should be directed to the promotion and extension of the system which has already demonstrated its effectiveness and whose future we are anxious to safeguard."

ARTHUR C. BACHMEYER

Director
University of Chicago Clinics

"Governor McGrath's article is most interesting. The principles he has outlined are, in my opinion, sound and no doubt will meet with general approval. Legislation along the lines proposed in Rhode Island by the other states will be far preferable to the proposed federal program and would offer a better solution to this problem."

Building Program Makes Progress

SISTER M. ANCILLA
Superintendent
St. Francis Hospital
Peoria, Ill.

HAMILTON B. DOX
Architect
Peoria, Ill.

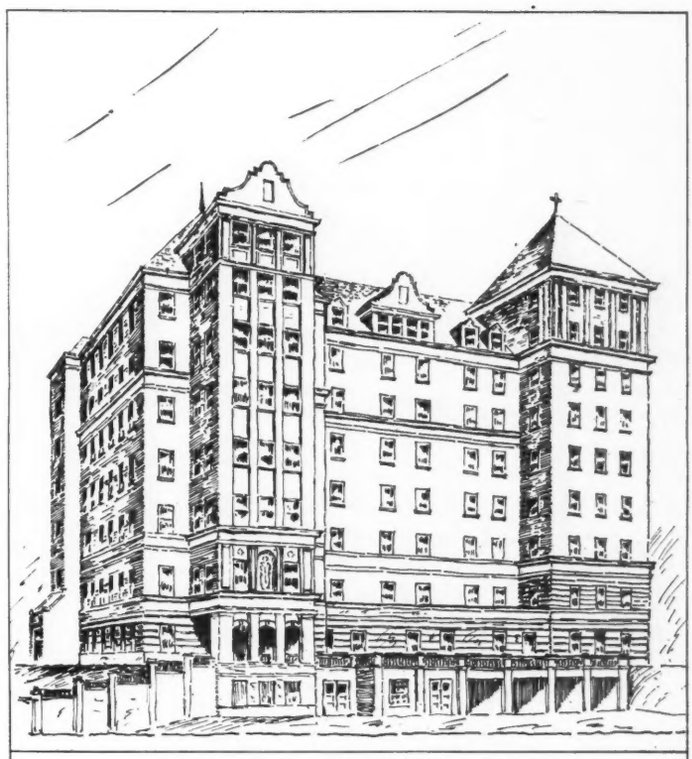
LATEST addition to a modernization program started in 1936 at St. Francis Hospital, Peoria, Ill., is a new eight story and basement wing, approximately 155 by 50 feet, which contains most of the central service facilities for the entire institution.

The first floor is divided into two parts that have no direct connection between them. At the south end are a waiting room, restroom and two emergency operating rooms opening off the corridor that connects the covered ambulance-patients' entrance with the old building.

In the north end are located the kitchen, dietitian's office, special diet kitchen and special diet and private dining rooms. The prepared food is transported to all floors by automatic food handling equipment which makes it possible to serve any patient within five minutes after the food is removed from the steam tables in the kitchen.

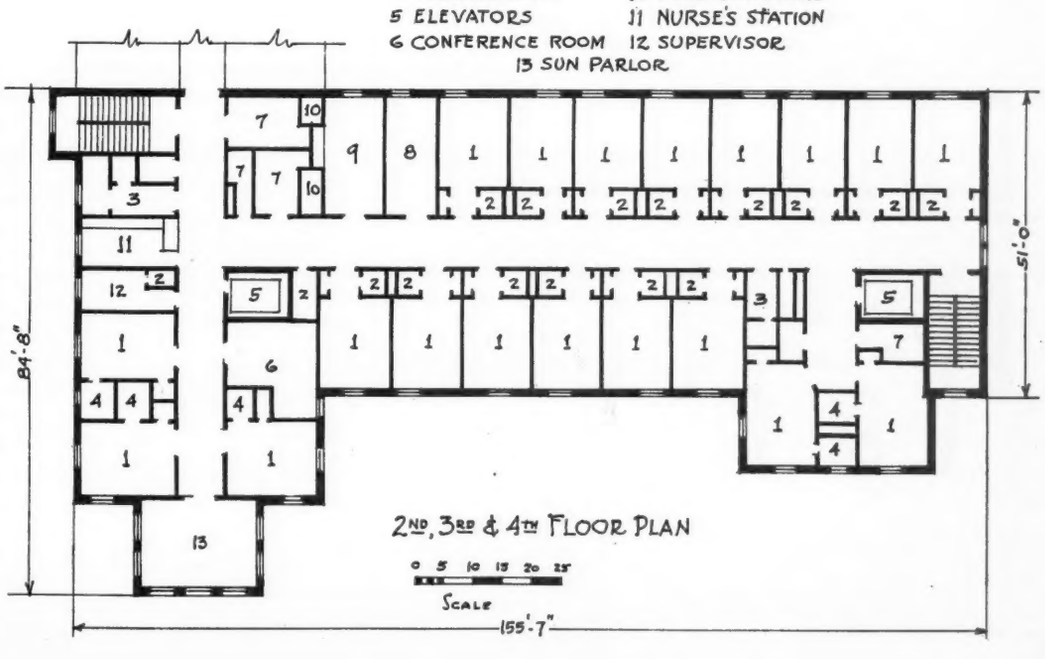
An outstanding feature of the new building is the installation of a conduit system of air conditioning that eliminates the sheet metal ducts formerly used.

Outside air, cleaned and properly humidified in a central air condi-



ADDITION TO ST. FRANCIS HOSPITAL
PEORIA, ILL.
HAMILTON B. DOX, ARCHITECT

1 PATIENT'S ROOM
2 TOILET
3 GENERAL BATH
4 PRIVATE BATH
5 ELEVATORS
6 CONFERENCE ROOM
7 STORAGE
8 UTILITY
9 FOOD SERVICE
10 FOOD CONVEYORS
11 NURSE'S STATION
12 SUPERVISOR
13 SUN PARLOR



Right: The second, third and fourth floors are all private patients' rooms, each with toilet room containing closet and lavoratory; five rooms on each floor have full bath. The corridor is T-shaped, with the nurses' station located at the end of the long corridor across the short corridor. Each room has an oxygen outlet connected to the oxygen piping system; nurses' call outlet, and wall-mounted combination speaker microphone.

1

2

SCENES AT ST. FRANCIS

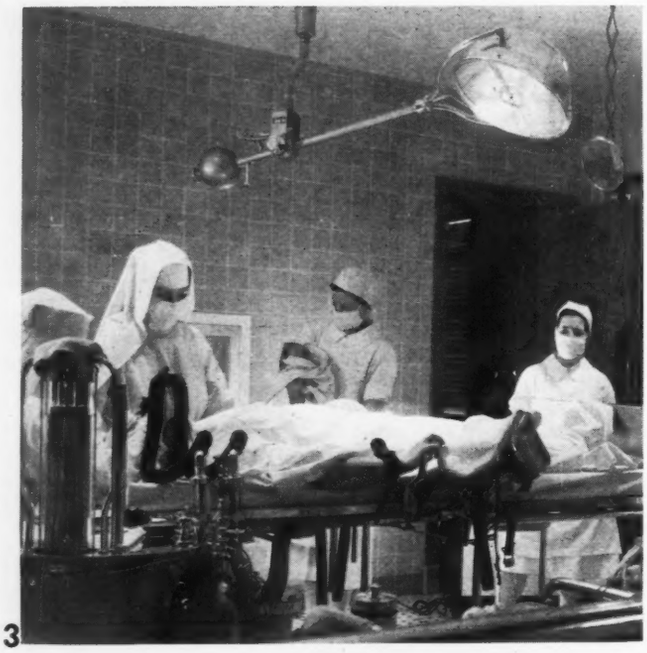
1. In the nurses' station are located the pneumatic tube system station, chart desk, narcotic cabinet and medicine sink, and desk unit for the combined nurses' call, radio and intercommunicating system.

2. The kitchen contains butcher shop, vegetable preparation, salad preparation, ice cream and pot washing rooms, separated from the main kitchens by a six foot partition. Stoves, griddles and ovens of the diet and main kitchens are gas-fired.

3. One of the four delivery rooms in the obstetrical department on the fifth floor. This floor also houses 10 labor rooms, two preparation rooms, doctors' rooms and showers, waiting rooms, toilets and sterilizing room.

4. Sterilizing room showing the two 20 by 48 inch double end pressure instrument sterilizers.

5. Each patient's room is equipped with steel furniture, including posture bed, bedside and overbed tables, desk, dresser, straight chair, easy chair and foot stool.



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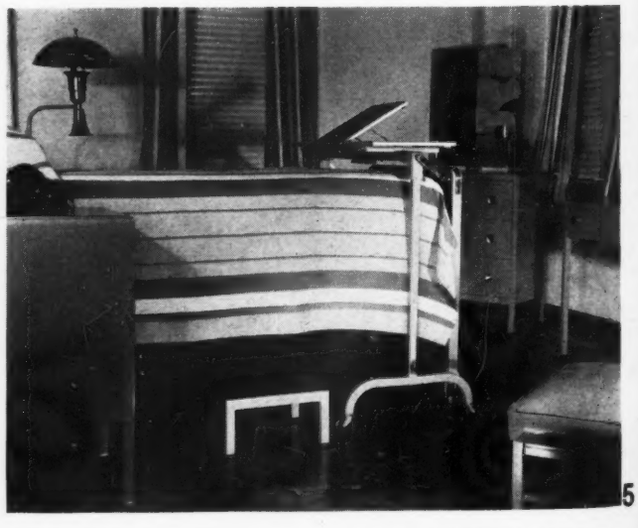

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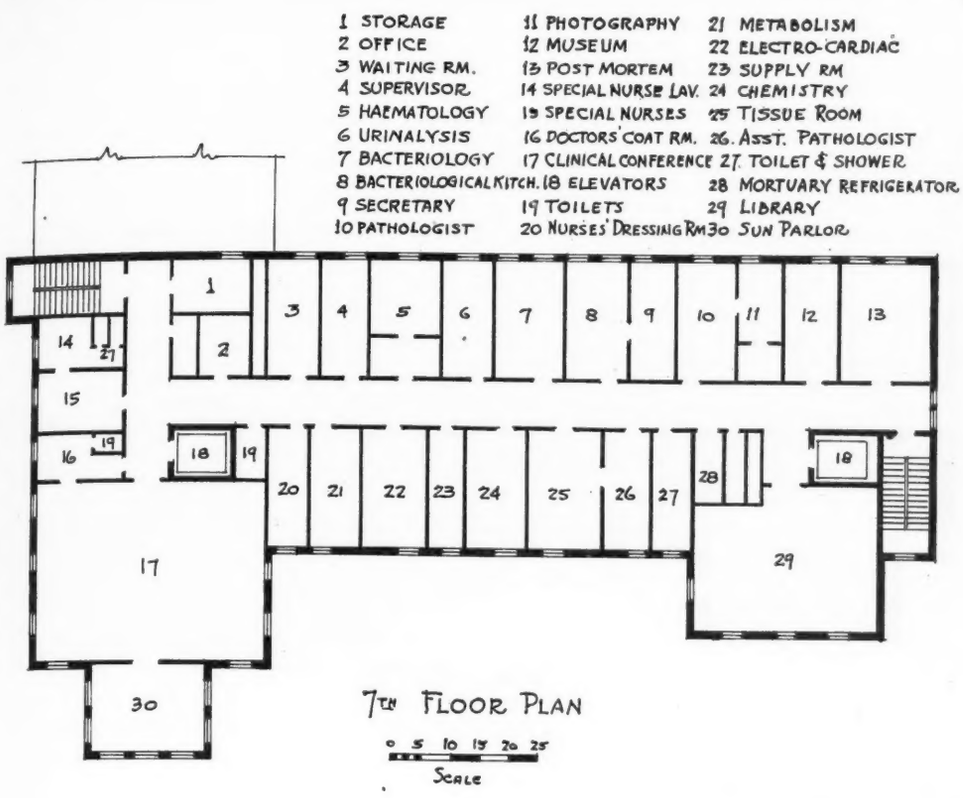
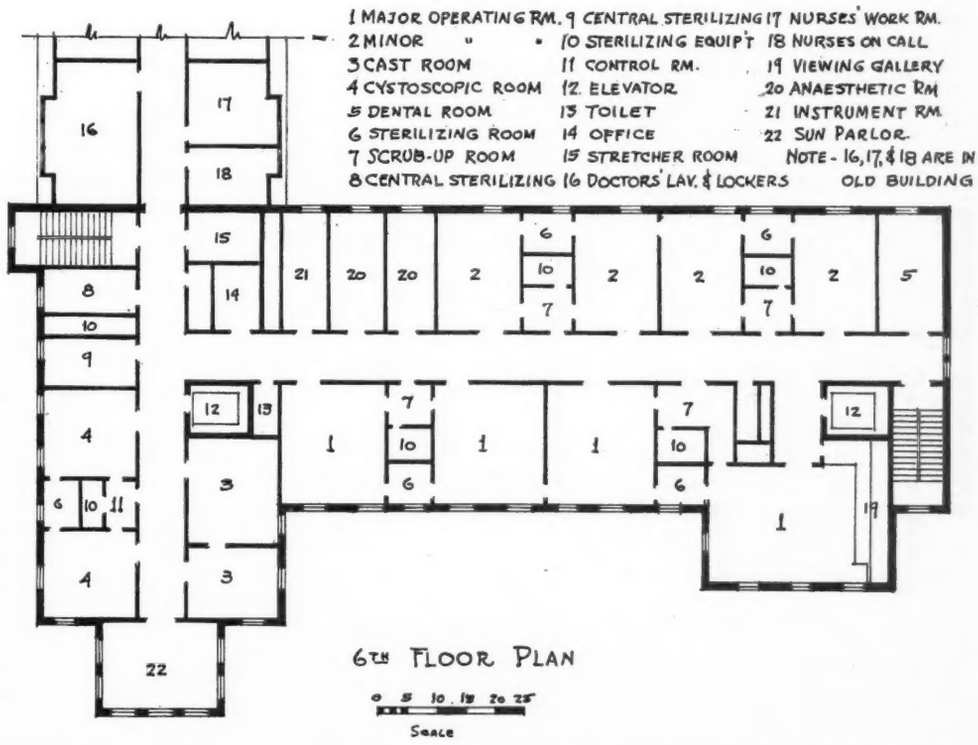


Left: The seventh story is the laboratory floor and houses the following rooms: postmortem; mortuary cooler; museum; pathologist's office; secretary's office; bacteriology kitchen; bacteriology, hematology, urinalysis, microphotography, chemistry and histology laboratories; resident pathologist's office; technical library; clinical conference room; laboratory supplies; toilet and service rooms.



The surgery on the sixth floor includes four major rooms, four minor rooms, two genito-urology rooms, two cast rooms, two pre-anesthesia rooms, central sterilizing and dental room. Recessed in the wall of each operating room is a cabinet containing valved outlets for suction, air, nitrous oxide, oxygen, ethylene and helium and an x-ray viewing cabinet.

tioner, is delivered in a conduit to a unit in each room. This unit, which takes the place of a radiator, has water pipe connections with a boiler and a refrigerating system located in the basement of the hospital. In the winter hot water flows through the pipes and in the summer, cold water.

A winter-summer control valve enables the occupant of the room to have the air heated or cooled, as desired.

All private rooms, clinical conference rooms, waiting rooms, solariums, operating rooms and offices in the addition are air conditioned.

Each of the delivery and surgical rooms has a small system complete in itself for that one room with automatic controls to maintain the desired temperature and humidity conditions.

The cost of the new building per cubic foot was approximately $1. This fairly high figure is due to several factors: the summer and winter air conditioning; the elaborate mechanical equipment; private toilets and lavatories in each patient's room; the piping of oxygen to each patient's room; the necessity of joining the wing on to an older building, and the fact that the site is on a hilltop of varying slopes, which necessitated carrying many of the column footings to a considerable depth.

A Week End With the Angels

E. B. WHITE

BECAUSE of the war the situation in hospitals is, of course, serious. A civilian feels embarrassed to be there at all, occupying valuable space and wasting the time and strength of the nurses, the student nurses, the nurse's aides and the Gray Ladies. But I discovered that there is a new spirit in hospitals which, in its own way, is as merciful and resolute as the old, and every bit as mad.

A patient, when he enters, receives a booklet reminding him that hospitals are short-handed and asking him not to bother the nurses unnecessarily. If he is a person of any conscience, he takes this quite literally, resolving not to push his call switch unless he is bleeding to death or the room is on fire. He throws himself so violently into the spirit of the emergency that, in the long run, he probably causes just as much trouble as he would have in more relaxed circumstances.

I hadn't been off the operating table two hours and was still heavily drugged with morphine and bleeding at the nose when I found myself out of bed, armed with a window pole, engaged in a hand-to-hand encounter with a sticky transom. I enjoyed the nonsensical sensation of being in contact with the enemy. The effort, because of my condition, was rather too much for me and I just made it back under the covers in time. There was quite a to-do up and down the halls when they found I had been out of bed.

The Morning Chores

As for routine chores, I did them myself, for the most part. Each morning I arose from bed and went at the room, tidying it up and doing all the dozens of things that need doing in an early-morning sickroom.

First, I would get down and crawl under the bed to retrieve the night's accumulation of blood-soaked paper handkerchiefs, which formed a dismal ring around the scrap basket where I had missed my aim in the dark. Then I'd fold the night blanket neatly and put it away in the bottom drawer of the bureau.

I would crank up the bed, take the creases out of the rubber pad, tighten the drawsheet, pat the pillows back into shape, straighten out the *Atlantic Monthly* and transfer the chrysanthemums into their day vase. Ashtrays had to be emptied, soiled towels removed, the hot water bottle exhumed from its cold grave at the foot of the bed.

One morning, in one of those passionate fits of neatness which overwhelm me from time to time, I spent an hour or so on my hands and knees clearing the room of bobby pins left by a former occupant. It was interesting work but, like all housework, exhausting.

For patriotic reasons I seldom rang and so was seldom visited. Once I had a bath. This was the second morning after my nasal surgery. A nurse came in early. Without a word she flung open the door of the commode and extracted a basin, a washcloth, and a piece of soap.

"Can you take your bath?" she asked briskly.

"I always have, in recent years," I replied.

She placed the bathing equipment on the rude table that arched the bed, and handed me a towel. "Take off your uppers and work down. Then roll up your lowers and work up," she snapped. "And don't get the bed wet!"

I waited till she disappeared, then got noiselessly out of bed, removed the basin, emptied it, went into the bathroom which I shared with another fellow, drew a tub, and had a nice bath. Nurses are such formalists.

Of all the memories of this fabulous and salutary week end, the most haunting is my recollection of the strange visitations of a certain night nurse. She came on duty, I was told, at midnight, and went off at seven. It was her custom to enter my room at a few minutes before five in the morning, when my sleeping potion still held me in thrall, snap on the light, and take a temperature reading. At her entrance I would rouse myself, at enormous physical cost, blink foolishly at the light, and open my mouth to receive, under the thick curly tongue, the thin straight thermometer.

The nurse, whose name began with an "A" and ended in a thornbush, would stand in beautiful serenity, gazing peacefully down upon me for the long three minutes required for the recording. Her lips held the faint suggestion of a smile, compounded of scorn and indulgence. Motionless and cool in the lamplight, faithfully discharging her preposterous duty in the awful hour of a day born prematurely, she seemed a creature tinged with madness and beauty. She seemed, but of course could not have been, without flaw.

Beauty and Lunacy Blended

As my drugged senses struggled vainly to catalogue her features, the thermometer would press upward against my tongue and the mercury would begin its long tedious climb toward the normal mark. I have no idea whether she was tall or short, dark or fair, plain or pretty, but in her calm and unreasoning concern about my body heat, at that unconscionable hour, she personified the beauty and lunacy of which life is so subtly blended. On the last morning of my stay I broke the mystical silence which had always before surrounded our ceremony.

"Cousin," I managed to mumble, allowing the thermometer to clash pitilessly against my incisors, "why dost wake me before the dawn for this mild dumbshow?"

She never changed her expression, but I heard words coming surely from her lips. "There's a war on, Bud," she replied. "I got twenty-six readings to take before I go off duty, so just for the heck of it I start with you."

Smiling a tiny proud smile, I raised my right hand and made a V, the way I had seen Churchill do it in the pictures. Then the drug took hold of me again, and when I awoke she was gone. Next day so was I.

Excerpt from "Week End With the Angels." Copyrighted. Reprinted permission the *New Yorker*.

Prevention Pays Off at 16 to 1

Every hospital can, and must, become a public health center

WILSON W. KNOWLTON, M.D.
Superintendent, Boston Lying-In Hospital, Boston

ODDS of 16 to 1 are indeed attractive if you can be sure of that long shot. For our present discussion that shot is guaranteed by the axiom that "an ounce of prevention is worth a pound of cure." A program of prophylaxis has many advantages over one of therapy alone. Yet the latter invariably comes first even with thoughtful people. Only from the remembrance of sad experience do we come to realize that it is wiser to pay moderately now for the absence of a pain later than to pay lavishly later in a frantic attempt to get rid of that pain then.

Hospitals, as we know them today, are the attractive and efficient descendants of the *hospitalia* (guest rooms) of ancient Rome with the emphasis on the guests' health added by the hospices of the great religious orders of the Middle Ages. Naturally, therefore, our hospitals are places of healing.

Yet a modern hospital should do more than cure disease. It should play an active part in the prophylactic public health program of its community. It itself should be a community health center.

Health Centers

Now any hospital, regardless of its source of support or type of patients, can be a health center. Environment, though, does help. The lone rural or suburban community hospital finds itself the inevitable center of local therapeutic medicine. Moreover, such a hospital draws financial support from a geographically circumscribed group of thoughtful citizens. The same citizens are served by some form of local health officer, ranging all the way from a paper phantom in the files of the state board of health to a really efficient local health unit.

Close cooperation within the community between those responsible for therapeutic medicine and those responsible for prophylactic medicine is a most desirable goal. No, the goal should be set beyond cooperation to that point of biological interdependence denoted by "symbiosis."

The urban hospital that finds itself not alone in the local therapeutic field has a somewhat different approach to the community health center problem. Some cooperation with the local health officer may well mark in the public eye the limit of the hospitals' relationships to the local public health program. Not everything, however, readily meets the eye.

In an attempt to comprehend the great variety of ways in which any one of the several hospitals in the community may play its 16 to 1 shot, let us start with the organization of community social welfare resources.

Community Planning

Every private charity hospital in a large urban community should align itself with the local hospital council or council of social agencies. If no such local body exists, help to get one started. A simple meeting of hospital administrators may serve to start the machinery of organization which should focus on local hospital problems the points of view of hospital executives, hospital trustees, the social welfare agencies, the public health department and Mr. John Q. Public himself. Good patterns for such councils exist and are available to the civic leaders of any American community.

The alert, public health conscious hospital does not get that way by accident or, at least, accident cannot be relied upon as the sure means of producing this consciousness. The stimulus of the local council of hospitals is a factor of force.

A sense of community obligation that pushes beyond the hospital's own front yard can often be found in some of the institution's trustees. Their interest may be fanned by a public health minded administrator, or they may be the ones intentionally so to fan the administrator. If he requires much stimulant, however, he fails in an important line of leadership. It is he who must set the pace for the hospital he represents.

Administrator's Challenge

The administrator should learn his way around town. He should know the local health officer at least well enough to permit of ready and informal exchange of ideas between them. He should understand what the health officer has for a community health program. He should know what facilities the health officer has at his command, facilities in terms of personnel and of equipment. He should know the manner in which the local health officer fits into the larger program of the state health commissioner. He should know how the latter official adapts for his state the surprisingly individualized federal health programs of today.

All this is a big order. It may be reduced, however, to the simple truth that, for the good of the individual hospital and of the patients it serves, the administrator must take an active extramural interest in the application of prophylactic medicine to his community.

Now how shall he apply that ounce of prevention within the hospital walls?

Home Missionary Work

In the first place those very walls and the equipment they enclose should more than meet minimal standards for health and safety. The local building code will be followed not only in the original construction but throughout subsequent repairs

and alterations. Fire prevention and control constitute too evident a need to warrant any elaboration here.

Occupational hazards for employes are pretty sure to exist throughout the institution. How about safety guards on laundry machinery, motorized kitchen equipment, repair shop tools and elevators? How about the danger of the exploding of anesthetic gases? And how about the health of *all* employes, student nurses, house staff physicians?

Are all food handlers checked *promptly* and thoroughly with an eye for typhoid carriers? Is every nursery nurse free of pulmonary tuberculosis? In short, one must be sure his own house is in order and is kept in order. Then he may turn to other phases of his part in the local public health program.

Some of the world's best missionary work is done close at home. The hospital clinicians should possess that public health alertness that means early diagnosis of any communicable disease. This attitude is of prime importance to the hospital itself, since cases missed in the outpatient department or during the admitting examination may blossom out to infect an entire ward. Attendants may then have been needlessly exposed, too.

With early diagnosis goes prompt reporting. Here many a clinician slips a bit. He puts off reporting until all the evidence is in when he might have contributed to the community defense by earlier reporting of a provisional diagnosis to be confirmed or disproved later. This, of course, is not always necessary or even desirable, but it is vastly preferable to the attitude that views reports as needless paper work.

Truly, the clinicians are advance scouts for the public health epidemiologist. With them work the bacteriologist and laboratory technician. Do you check duplicate smear and culture specimens with your local health department laboratory?

The hospital plays still a further part in epidemiology. Sources of infection and contacts can often be spotted from the patient's clinical history. In fact, the attending physician is often the best, sometimes the only, source of epidemiological control in syphilis and gonorrhea.

Leave to the health officer those public health problems that submit to environmental control. Work with him—perhaps in place of him—when protection of others depends upon the attitude and cooperation of the individual patient. Support the health officer in the eyes of the patient and his family.

The clinical side of medical practice has long missed the full potentialities of prophylactic immunizations. The hospital out-patient department, as well as the private practitioner's office, can do yeoman service in the health officer's program for controlling such scourges as smallpox, typhoid fever and diphtheria. Let the patients know that the hospital aims to do more than cure them. The local health department should be a prolific source of dignified, effective, educational exhibits for use in medical waiting rooms.

Some urban hospitals enjoy the advantages of providing within their walls private office space for the members of their visiting staffs. This arrangement has numerous points in its favor, including the opportunity for helping the staff men in their attack on those public health problems that need to be approached by way of the patient-physician relationship.

Social Service

The hospital social service department is another factor of importance in the modern concept of public health work. The skillful medical social service worker fits the physician's orders into the patient's social and economic scheme of life. She (or he) may do more than this, if the current local public health needs are recognized by the hospital.

Modern public health work deals much more with individuals than with their environment. Its best approach to the individual is through his physician and his hospital for which the medical social service worker is often the interpreter.

Research

Research in problems of therapy often brings an answer to the associated problem of prevention. Invaluable guidance of the research work carried on in our large university teaching hospitals comes from the collaborating scientists in the associated medical schools and schools of public health. Such work may well take on renewed local hospital interest when returning soldiers or postwar air travelers present disease pictures alien to temperate America. Here, indeed, will be real problems of instant importance to the clinical practitioner, to the hospital superintendent and to the local health officer.

Yet research of daily interest to the hospital administrator need not await the importation of some strange and bizarre lesion. The hospital that contributes even a little to the present work on dental caries is fighting in the front line of prophylactic medicine.

The Specialities

A number of medical specialities may be cited with merely a hint as to their respective public health potentialities.

What part can child guidance clinics and far-seeing medical social service workers play in the prevention of mental disease?

What do the industrial physicians in your city expect your hospital to do in the health education of sick workmen and their families?

Are you proud of the maternal and neonatal death rates on your obstetrical service?

Can you and your local health officer develop a better control over the health of the individual preschool age child, not only to keep him well now but also to prevent him from laying the cornerstones for illnesses of later years?

The population of America is growing old. Is geriatrics in your hospital vocabulary yet?

How about a pension plan for your faithful institutional employes?

Paternalism

Our hospitals will, of course, continue to be places of healing. Someone, though not always the patient, will continue to pay for the relief of his pain that could not be, or at least was not, prevented. That these financial payments are now made with greater and greater difficulty is evident from our efforts to spread the load through the insurance principle.

The feeling of public responsibility for the welfare of the individual is being sharpened. Skip the question as to whether or not this is wholly good for the individual. He likes paternalism. He is out to get it. Herein lies a challenge to every thoughtful hospital trustee and administrator. How can we encourage the patient to think clearly as to his financial responsibility to his loyal

family physician and to his hospital that stands for more than mere cure?

Summing Up

Obviously, no one hospital can do everything. In fact a particular hospital does well if it makes a single specific contribution to the general public health movement of today. Get to know your local health officer personally. Work with him. Help him. With his help select your own hospital's potential contribution to preventive medicine. This contribution may be small; it may be large. It can be definite, if you will only plan it so.

The Colored Man and the Blue Cross

JOHN L. PROCOPÉ
Superintendent, Flint-Goodridge Hospital, New Orleans

DURING the last decade, America has witnessed a marked growth in the sense of responsibility held by the federal government and the states for improved health conditions for all the people. Evidence of this growth is seen in the various grants-in-aid to state governments, in the Children's Bureau program for crippled children and in the recently developed program of maternal aid for soldiers' wives. The latest evidence of this interest is found in the proposed federal health subsidy implied in the Wagner-Murray-Dingell Bill.

Some Weaknesses Overlooked

Hospital and group plan authorities have voiced their opposition to the bill and the grounds for their opposition are already well known. However, it may be that they have overlooked some weaknesses in their programs of hospitalization which, if corrected, might help to forestall the threatened encroachments of the federal government.

First of all, let it be noted that the benefits of the Blue Cross plans have not yet been extended to large numbers of the American population. This is particularly true as concerns the Negro group. The Negro has been systematically excluded from many of the blessings of "the American way of life," blessings that have been automatically extended to other Americans. Because of American social mores, he has been consistently denied most of the things that would have spelled for him the Good Life.

Only a comparatively few Negroes have been enrolled in Blue Cross plans. This is no fault of the Blue Cross itself but results, in part, from the following situations that are inherent in the Negro's rôle in American life:

1. Exclusion from employment at those economic levels in which enrollments have been emphasized.
2. Exclusion from the plans in cities in which segregation patterns obtain.

It has been fairly well established that, until the outbreak of the war, 90 per cent of Negro wage earners had an income of less than $1000 annually. Inescapably, they are found on the lower third of our economic ladder. They are unskilled laborers, domestic servants, farmers and workers in small firms where only one or two Negroes are employed. They are part of a large group of workers to whom hospitalization plans have not been extended.

The charity load in tax-supported hospitals has not been much reduced through Negro hospitalization under the Blue Cross. Then, too, at the beginning, the semiprivate rates of most plans were too costly for them. A further objection given by the potential subscribers is that the physician's fee had to be met by the subscriber. Too often, the plan meets with the objection that, even without hospitalization insurance, potential subscribers in the lower income groups can get free medical and hospital care at the tax-supported hospital.

Presumably, private enterprise can do a better job than government, all things being equal; nevertheless, if the Blue Cross plans hope to make a compulsory government plan unnecessary, they must devise schemes to enroll 10 times the 12,000,000 persons now under the Blue Cross and encourage the growth of medical plans.

The plans, both hospitalization and medical, should arrange to enroll voluntary groups in large numbers, groups such as constitute the memberships in church, club, fraternal, civic and residence block organizations, as well as farmers and domestic servants. Even some form of periodic enrollment of individuals is perhaps not without merit. All workers in this lower economic stratum, whites as well as Negroes, are excluded as beneficiaries of the plans, but the exclusion affects the Negro more strikingly because a larger proportion of Negro wage earners occupy this lower level of activity. The hazards of the cost of illness should be removed for all the people.

Wider Coverage Reduces Cost

A widening of the hospitalization coverage should ultimately reduce the cost of upkeep of municipal and other tax-supported institutions and should also strengthen the financial structure of the voluntary hospital. It would also help to bring a greater consciousness of individual health responsibility among lower income people and so, indirectly, improve the public health.

The social aspects of a government compulsory hospitalization plan are inimical to the American way of life but, if the government's overt suggestion hastens the day when private enterprise will voluntarily put hospital and medical facilities within the reach of all people without the stigma of charity, then we may all be glad that the government has caused health agencies to rethink the goals of their programs.

From a talk before the National Conference of Hospital Administrators, November 1943.

The hostess is ready to run errands, write letters, make a telephone call or just sit and talk with the patient who seems to be enjoying her visit.

VOLUNTEERS *Cement the Bond* between hospital and community

HOWARD S. PFIRMAN
Administrator, Middlesex Hospital, Middletown, Conn.

THE volunteer program at Middlesex Hospital, Middletown, Conn., is divided into two parts, permanent and temporary. The hospital auxiliary is considered the permanent part of the program while the temporary organization includes the Red Cross nurse's aides, Red Cross motor corps, Red Cross canteen, Middletown police department and men's volunteer corps.

Hospital Auxiliary

The permanent volunteer organization consists of the chairman of the following committees each performing the work as indicated.

Linen Committee: Repairs, cuts and inventories necessary articles from materials provided by the hospital. The articles are to be completed by the hospital auxiliary groups throughout the county.

Gauze Committee: Assists the hospital in the preparation of surgical and other dressings.

Library Committee: Has charge of all library equipment at the hospital and directs a distributing staff so that the patients may have adequate reading material.

Personnel Committee: Maintains the membership of the auxiliary, sends out the *Auxiliary News* and promotes the improvement of public relations between the hospital and the community.

Project Committee: Plans projects that contribute to the growth and development of the hospital.

Volunteer Service Committee

In the spring of 1942 when the manpower shortage started to become serious the hospital auxiliary council, consisting of the chairmen of the committees listed, a presiding chairman, secretary and treasurer, recognized the need for assistance of auxiliary personnel in the hospital. A new committee known as the volunteer service committee was formed, the chairman being given a place on the hospital auxiliary council. The duties outlined were "to organize volunteer service within the hospital in cooperation with the administration and the board of directors."

It was hoped that through the addition of this committee the hospital auxiliary, which is a permanent organization, would share in the new experience and thereby avoid an all too common pitfall.

We had heard of another hospital in which the older organization resented not being given an opportunity to share in the more direct form of service. This resulted in unhealthy rivalry between the two groups, which was not beneficial. The volunteer service committee of the hospital auxiliary, as a part of the permanent organization and performing the new type of patient service, successfully bridges this gap.

As soon as this committee was formed the chairman became active and organized its membership to perform the following duties: arrange flowers, deliver mail, work in the supply room, pass trays at dinner and supper, act as visitors' receptionist and perform clerical and "general" work.

General work consists of those numerous jobs that are considered undesirable, such as cleaning ice boxes, sweeping and cleaning utility rooms. As a result of this addition not only new members of the hospital auxiliary but many members of the numerous hospital auxiliary committees were given an opportunity to serve in this more active and frequently more satisfying capacity in the hospital.

Hostess to Patients

It was recognized early in 1943 that the volunteer program was of such importance and the volunteers were becoming so numerous that

someone would have to devote time to its continual supervision. After reading an article in The Modern Hospital on the work done by the hostess in another hospital, this position was created. The hostess has the responsibility of visiting all patients, purchasing for them such articles as cigarets, magazines, ice cream and bobby pins and making telephone calls, as well as "just talking" with the patients.

While she was becoming adjusted to the half-time position for the first few months, our hostess was invited to attend a morning conference. In this way, she was introduced to the numerous problems and policies of the hospital organization. She was also requested to take the various training-within-industry courses given at the hospital in cooperation with the War Manpower Commission so that she could make out a job analysis of each duty to be performed by volunteers.

After she had received adequate training the hostess assumed the duties and title of "coordinator of volunteer service," becoming a full-time employe. She then understood the hospital policies, had an actual understanding of the numerous tasks to be performed by volunteers and, with the help of the training-within-industry course, was able to make out a job analysis for each volunteer job to be performed. She is, therefore, able to supervise and schedule numerous jobs in the volunteer program and also continue her hostess work.

The temporary volunteer organization consists of the Red Cross nurse's aides, canteen corps and motor corps, the Middletown police department and the men's volunteer corps. All of these were organized so that the hospital service might be maintained in spite of the personnel shortage brought about by the war.

Nurse's Aides

This group, like the other volunteer organizations, is self-governing. A council consisting of one representative from each graduating class —there have been eight—elects its president, vice president, secretary and treasurer. The eight members are then divided into educational, entertainment, schedule and publicity committees.

The educational committee arranges for constructive educational programs at meetings held once a month. These programs consist of lectures by physicians or they may pertain to hospital treatments and procedures or to procedures of other organizations, such as the district nurse association.

The entertainment committee provides the entertainment or social side of the program, which may consist of a moving picture and refreshments.

The schedule committee schedules the services of the nurse's aides in the hospital and in the community. These schedules are prepared in advance and if the nurse's aide is unable to come to the hospital as scheduled it is her responsibility to get a substitute aide for that period. If she is unable to locate a substitute, after making several attempts, she calls the chairman of the schedule committee and the chairman takes over, endeavoring to obtain a substitute for the period.

In view of the fact that the schedules are made out two weeks in advance, they are turned over to the publicity chairman who arranges with the local newspaper to have them published. The schedule chairman also has the responsibility of keeping a scrapbook of news articles, social events and pictures pertaining to the affairs of the nurse's aides.

The organization has by-laws and charges dues of $1 a year (10 cents a month for 10 months—no meetings during July and August). The officers and committees serve for a term of one year.

Canteen Corps

In accordance with our policy of having each department carry its own responsibilities, it was considered desirable to have all nourishments under the direct jurisdiction of the dietary department. This was done with the aid of the Red Cross canteen corps. All nourishments were withdrawn from the dietary kitchens and a system was arranged whereby each patient when filling out his in-

Among the important tasks performed by members of the Red Cross canteen corps is the assembling of nourishments.

Ambulance service is handled by members of the Red Cross motor corps, men volunteers and the police department. Usually an orderly or male volunteer accompanies the motor corps girls on ambulance calls, but if no man is available, they go out alone and thus far have had no difficulty in this work.

dividual menu also checks the nourishment he desires for the following day. These nourishments are assembled by the canteen corps on a stainless steel "nourishment" truck three times a day and delivered by members of the dietary department to the patients.

After the canteen corps had been assisting for many months in this and other capacities in the dietary department, it was learned that the therapeutic dietitian was joining the dietitians' corps of the Army. Finding no dietitians available, the canteen corps was called upon and some 20 members took special training and are now performing many of the services of the therapeutic dietitian.

Ambulance Corps

Following the loss of numerous ambulance drivers to the Army, this service was covered day and night through the cooperation of the Middletown police department until the Red Cross motor corps offered its services and the following arrangement was completed:

The motor corps was given a room on the hospital premises with telephone communication. Two motor corps members report to the hospital every night from 7 p.m. to 7 a.m., have midnight lunch and breakfast at the hospital and leave in the morning after tidying up their room and making up their beds.

When calls are received the drivers go out with an orderly or a member of the men's volunteer corps. If conditions are such that neither is available the call is made without a man accompanying them and after many months of operation no untoward incident has occurred.

The motor corps works Monday through Friday while Saturday and Sunday nights are covered by the men's volunteer corps and the police department. Monthly meetings are held by the motor corps at which time problems are presented and suggestions are made.

Men's Volunteer Corps

The men's volunteer corps, known as the M.V.'s, was organized during the fall of 1943 when manpower became practically nonexistent. The first class consisted of 28 members, many of whom are in professional life.

The M.V.'s were given a ten hour course and started volunteer work within the hospital before the course was completed. They wear blue wrap-around three quarter length garments with Middlesex Hospital M.V. insignia on the pocket and are given bars and stars according to the amount of service rendered. Their activities cover a wide range, including the usual orderly and housekeeping work, laundry and numerous types of maintenance work in addition to frequent coverage of ambulance service.

The organization is loosely knit having only a director and associate director in charge as executive committee. These two members meet with the coordinator of volunteer service and the three meet with the administrator every month to discuss policies and the further development of their organization.

It is understood that no volunteer performs any job unless paid employes are not available. Each volunteer is covered by $200,000 personal liability insurance, as well as compensation covering all medical expenses resulting from any injury while "working" at the hospital. For purposes of insurance premiums and the hospital records, every volunteer signs in and out every time he or she works at the hospital.

As a result of the volunteer program, the hospital's service and needs are now being more intelligently interpreted to the community than ever before. A friendly bond has been cemented between the hospital and its volunteers and, most important of all, the service to the patient is being maintained.

Blue Cross Plans Can Do the Job

RAY F. McCARTHY

Executive Director,
Group Hospital Service
St. Louis

IF the American people desire to preserve the voluntary hospitals

IF the plans can help hospitals to educate the public to the value of maintaining this system

IF they can quickly spread the benefits of Blue Cross protection to a much larger section of the population than is now covered

MOST Blue Cross plans are doing outstanding work as the service arms of American hospitals; they have a magnificent record of achievement which is attested to by the voluntary enrollment of American working people and their families, numbering 13,000,000.

This has been accomplished primarily because American hospitals guarantee the service benefits and the ethical standards of the Blue Cross plans. Wise leadership of civic leaders, local medical societies and community institutions have helped obtain for Blue Cross plans their present enviable position.

There can be no lessening of responsibility to the hospitals and the public under the pretext of prodding by pseudo-architects of the new social order. All the cooperating voluntary hospitals took courageous steps in giving material assistance toward the inauguration of these nonprofit community plans. Administrators and trustees were justifiably skeptical of results that might be obtained as each expansion was made by the Blue Cross plans.

Actuarial Data Unequaled

The experience and actuarial data developed by the Blue Cross plans now surpass any in the hands of insurance experts or government bureaus. Many of the plans have excluded benefits which, in their communities, are considered to be a transgression on the rights of the medical profession and yet these plans may provide equal or greater benefits than those suggested by critics who have taken the contentious position that the plan should change community customs and administrative procedures and actually interfere with the relationship of the medical staff and the hospital.

With the passing of each year, Blue Cross plans have discarded certain enrollment procedures and acquired new ones. In Minnesota and Missouri, the plans have pioneered in the extension of this voluntary program into rural communities and among sparsely settled farm areas. Much remains to be accomplished in order to protect those engaged in agricultural pursuits.

Half of this responsibility rests squarely on the shoulders of hospital administrators and trustees in their respective service areas; 25 per cent of the responsibility rests on civic leaders, farm organizations and the local and state governments. The remainder of the responsibility for increasing enrollment in farm areas rests on the shoulders of executive directors and trustees of Blue Cross plans.

Blue Cross plans can do the job *if* the American people wish to retain the voluntary hospital system. This carries with it the parallel desire to retain their unassailable right to do charity and not give to any division of government the exclusive privilege of caring for the medically indigent. Trustees of plans should interest themselves immediately in being invited to confer with city governments in their postwar planning so as to aid modernization without encouraging unneeded expansion of facilities.

They can do the job *if* they will help the hospitals reawaken in the people a desire to maintain these American institutions. A tremendous amount of public education is necessary. There are still too many among our people who are totally unaware of the generosity of the medical profession and our charitable hospitals.

The modern hospital system was founded on Christian principles by religious groups. Certain phases of public health and certain types of institutional care were necessarily assumed by government. Blue Cross plans have the responsibility of strengthening the position of their member hospitals in their respective communities.

Use Reason, Not "Rabble-Rousing"

The kind of public education necessary to overcome the apathy of our people and to offset half truths requires careful planning that will effectively reach the different economic strata. Blatant opposition to proposed legislation will not be sufficient. Mass appeal to the American people is most certainly not an intelligent approach. They must be made to understand the position occupied by the voluntary and charitable hospitals in their own communities as it affects their own families, their own welfare.

A general query directed to hundreds of laboring people in St. Louis as to their attitude about the Wagner-Murray-Dingell Bill brought forth this response: "Why do the hospitals and the Blue Cross oppose the interests of labor?"

Some laboring people actually believe that the attacks upon the Wagner-Murray-Dingell Bill are in reality attacks upon the original Wagner Act which gave labor new rights and protection. It is our job to distinguish between the two Wagner bills.

A tower of strength in the development of our modern hospitals has

Presented at the Missouri Hospital Association meeting, St. Louis, November 1943.

been their ability to adhere strictly to community customs. The same essence of strength has not been sufficiently emphasized by the Blue Cross plans as an answer to those who are merely seeking millions more to be covered. Blue Cross plans are tailor made for each area they serve. Their basic structure, their service benefits and their rates take into consideration community customs, hospital administrative practices, medical ethics and the economic status and type of employment in the areas they serve.

I have reemphasized well-accepted principles because they are fundamental and primary points involving our whole voluntary hospital structure. The onrush of mislabeled reforms has on occasion made it appear necessary to forego some present practices and embark upon a new course. Few can point an accusing finger at the hospital field and claim that hospitals have ignored the need of meeting new and changing conditions in the health field.

When I say that "Blue Cross plans can do the job," I know that such a statement cannot be accepted literally without giving full recognition to the "ifs" upon which the statement is predicated. Sheer desire and wishful thinking by plan directors do not constitute the answer.

In addition to meeting current personnel and administrative problems, Blue Cross executives and staffs must take immediate steps to devise a program of accelerated membership. Many more persons must be given this voluntary protection quickly and without jeopardizing the financial position of the plans or the confidence of the participating hospitals.

How can it be done? It is not too presumptuous to say that the person who could answer this question would solve in short order the government threat to our hospital system.

Without attempting to evaluate completely the problems involved or the preliminary steps that might need to be taken, I suggest that every Blue Cross plan should be expected to enroll half the population of its service area within another five year period. Some steps to accomplish this would include the following acts to be undertaken by the plans:

1. Enroll farmers and rural groups on a community basis.

2. Train competent field men more intensively for civic leadership and educational work in rural areas.

3. Insist upon authorization for voluntary *pay roll allotment* of federal, state and municipal employes and the teaching groups.

4. Stimulate trustees of hospitals and of plans to require more active leadership among management groups and agricultural associations in helping establish new groups; invite labor groups to confer on the principles involved in the establishment of this voluntary program of health budgeting, and enroll labor unions on a vertical basis with pay roll deductions from union dues.

5. Develop a low-cost plan providing limited hospital benefits in accordance with available facilities; confer with hospital authorities on their expansion plans in the postwar period, and aid recognized authorities in raising hospital standards.

6. Recommend a cooperative program to provide protection to the medically indigent wards of federal, state and municipal governments. Be prepared to cooperate on both local and state levels to offer benefits and coverage to the medically indigent and, at the same time, do not forget the inalienable American right to do charity.

7. Implement student health plans in schools and colleges and, if necessary, provide a special "student hospital plan."

8. Maintain members already enrolled by an improved retention procedure with particular emphasis on continuing protection for families.

9. Act as clearance bureaus for out-of-town persons holding affiliated Blue Cross memberships and inaugurate a system whereby they will receive the same benefits and protection that are offered to resident subscribers in the locality in which they are hospitalized.

10. Continue to pay hospitals a fair per diem income so as to permit extension of charitable aid.

11. Urge national leaders to assist in obtaining transfer privileges for *all* Blue Cross members.

12. Employ a national enrollment director and an adequate staff to facilitate increased enrollment among firms doing business on a national scale.

In addition, the American Hospital Association must require strict adherence to approval standards and prohibit the rise of competitive practices between plans and hospitals.

Exchange Program for Employes

THE small hospital can offer many opportunities that are of value to its workers. Because it is necessary to combine the duties of several jobs in a single individual he acquires versatility, a rounded knowledge of the institution and a comprehensive grasp of how it functions. As he is closer to management there are opportunities to learn executive technics.

Many of these opportunities are denied the employe of the large institution because of the greater specialization of duties and lack of contact with management. On the other hand the worker in the small hospital will be under a certain handicap without the experience that only the large organization can give.

Would it not be advantageous to hospital management and workers if a system for exchange of selected personnel could be worked out? Employes in a small institution would gain valuable experience from a period spent in a metropolitan hospital. By assisting the administrator of a small hospital, a worker connected with a large organization will gain an over-all insight into hospital management that will help prepare him for more responsible work in his own hospital.

Employes desiring such training should be willing to use their vacation periods for work experience. The program should not require any more elaborate plan than correspondence between interested and cooperative administrators. A program of selected work experience and guidance should prove a valuable aid to morale and make for greater individual competence.—VINCENT A. WALKER, *admitting officer, Bowne Memorial Hospital, Poughkeepsie, N. Y.*

This Collection System

Is a CREDIT

to Albany Hospital

ARTHUR E. LIFFITON
Credit Manager
Albany Hospital
Albany, N. Y.

BECAUSE of the increasing amount of credit granted the average wage-earner, hospitals today are required in a great many cases to conform to the trend of the times and extend credit and take their chances of getting paid just as do the furniture store and the electrical appliance store. The only disadvantage to the hospital is that if the account is not paid it is not able to repossess the merchandise.

To guard against this situation, it has been necessary for hospitals to devise some method whereby arrangements for payment can be made either before or at the time of admission.

At Albany Hospital, Albany, N. Y., we have come to realize the tremendous importance of the advance reservation. This system requires the constant education of the staff men by the administration. A doctor might consider it a bother to have to advise the hospital of every patient that he sends in, but he will cooperate if time is taken to explain the reasons for, and the value of, the reservation to the institution, to the doctor and to his patient in terms of better relations and elimination of misunderstandings.

Doctor May Use Credit Data

One of the most effective ways of winning the doctor's cooperation is to assure him that he may have access to all of the credit information on his patient. When he finds that the hospital is willing to assist him with his own collection problems, he will be more than willing to help.

After the receipt of the advance reservation, the most important thing to consider is the advantage to which it may be used. The doctor calls in the reservation to the admitting officer who records the following information: (1) name and address of patient; (2) date of anticipated admission; (3) name of attending doctor; (4) rate and type of room requested.

This information is transcribed to a reservation book and the original slip is sent along to the credit department for further investigation.

Presented at the meeting of the Northeastern New York Hospital Association.

When the credit department receives notification of the anticipated admission, it starts to funcion in the following routine:

1. The name is checked against the paid and unpaid credit cards in order to determine whether there have been any previous admissions for the patient or any member of the family and, if so, what the pay experience was.
2. If we are unable to turn up any past record of the case and if the patient lives within a radius of approximately 20 miles, we immediately ask a commercial credit agency for a credit report.
3. The patient is then rated as either a weekly or an advance pay patient.

A weekly rating may be given a person who has a record of paying his trade obligations within thirty or sixty days, owns property, has a better than fair income, is well thought of in the community and has a record clear of judgments or accounts for collection.

An advance rating would be given to all those whose records indicate a small to medium salary, obligations in the trade, such as monthly payments on merchandise, number of dependents, records of judgments, accounts for collection, dispossesses and unsavory credit or character references.

This rating, plus any other information the credit department feels would be of value to the admitting officer when admitting the patient, is placed in the reservation book opposite the name of the patient.

Often the advance credit investigation uncovers extremely interesting information. It often discloses the fact that the patient had been in the hospital before as a welfare case and now, for some unknown reason, is coming in as a private patient. This, of course, is a danger signal to anyone who is responsible for the collection of that account.

Immediately upon receipt of such information, it is essential to discuss with the patient or the person responsible for payment of the bills the financial arrangements that have been made to meet the hospital bill. This can be done by mail or telephone.

Hospital Bill Estimated

It quite often develops that the patient has no idea of what the expense will be. It is then necessary to get in touch with the doctor to determine the probable length of hospitalization so that a bill can be roughly estimated and quoted to the patient, who can then be told the hospital's credit requirements.

If the patient is unable to show satisfactory financial responsibility, the case should be referred to the proper welfare district for assistance. The doctor will cooperate when he is advised that the patient should be a welfare case and will usually approve the admission as a charge to the welfare department.

Other cases commonly encountered include patients who are bad financial risks as shown on a previous admission when it was necessary to sue for payment of the bill, and those who have to be readmitted before having cleared up past hospital expenses. When the admission is not emergent, both types can be dealt with by getting in touch with the responsible relative and requesting payment of the old bill, as well as estimating the anticipated bill before admission.

Not only is the advance reservation a distinct help to the institution but it is also of benefit to the patient himself, for with the exception of obstetrical cases most hospitalizations are not planned in advance. Seldom is the money saved to meet the situation and to anyone in the habit of paying his bills, it is an obligation that has to be met. A credit manager or person in charge of accounts can be of great assistance to the payer by discussing the situation and suggesting various methods of raising the money.

Lessens Risk of Large Bill

Not infrequently a person in the low income bracket contracts for a private room or an accommodation other than that within his income and the credit manager can advise him to take a less expensive accommodation that is within his means. This will also lessen the risk of accumulation of a large bill.

Having touched briefly on the planned admission and the value of the advance reservation, we come to the largest credit problem confronting the hospital today—the treatment of emergency admission.

There are two types of emergencies, *i.e.* those that are sent in by the private doctor for immediate operation and those that arrive in the emergency room as the result of accidents.

The first type of case is usually the easier to control since the patient is almost always accompanied by a close relative. The patient is seldom held up in the admitting office and is sent at once to the floor for care. The relative is requested to stop in the office before leaving the hospital so that the proper history can be taken and the responsibility for payment can be fixed.

Fixing the responsibility for payment is generally more difficult than it sounds, for occasionally the responsible relative does not appear and the person who brought in the patient is wary of becoming financially involved.

However, the admitting clerk should definitely make some arrangement with that person to have the responsible individual stop to sign the guarantee for payment of the bills. This guarantee form is extremely important because it may later be the only security on file for an unpaid account.

If the admitting clerk has difficulty in eliciting the required information, she should refer the relatives to the credit manager who will explain the policies of the institution in regard to payment of the bills and make any necessary arrangements.

The next type of emergency admission, that of the accident variety, is the difficult case. The success or failure of the institution to collect depends a great deal upon the information that is received when the patient is brought into the emergency room.

The information that is of assistance to the credit department and that enables it to cope more intelligently with the situation and aid in determining the type of accommodation necessary is as follows:

1. How and where did the accident happen?
2. Was the patient injured while at work and, if so, who are the employer and his insurance carrier.
3. Was the person injured as the result of an automobile accident and, if so, was he the driver, a passenger or a pedestrian? Who were the other parties involved? Who are the insurance carriers?
4. Employer and type of occupation.
5. The patient's ability to pay hospital rates.

From this information it can usually be determined whether the patient is to be admitted as a compensation, private or ward service pay case or whether he should be admitted as a medical indigent or welfare case.

Lack of care on the part of the emergency room clerk or the trained social service worker in the interview with the patient or those who have brought him in might result in a definite loss to the hospital.

The most difficult type of accident case is that of liability. Many people are confined to the hospital through no fault of their own. Even though the hospital has no claim to any third party liability action, it is a tremendous problem to get the patient to pay his just obligation.

The patient invariably feels that he is not responsible for the hospital bill and that he will not pay until the accident claim is settled. Often the attorney handling the case advises the patient not to pay on the grounds that an unpaid bill has a direct bearing on the case. This is not true as responsible legal opinion states that payment of the hospital bill will in no way jeopardize the legal claim.

When a patient is admitted as a liability case, we insist that an advance payment be made and advise those responsible for the bill that we expect it to be paid each week and in full on discharge.

More and more people are beginning to realize that some form of hospitalization insurance is almost essential to their everyday needs. Almost all types of industry have some sort of group hospitalization benefit for employes and their dependents.

Time and again patients arrive at our admitting office and insist that their insurance policy entitles them to hospitalization and that presentation of the identity card on admission to the hospital should be sufficient security.

Policy Assigned as Last Resort

Most of these insurance policies have an assignment clause so that any benefits due the policyholder may be assigned to the hospital. At Albany Hospital we do not encourage these policyholders but insist that our bill be paid and reimbursement from the insurance company be made directly to the patient. Only as a last resort after careful investigation has disclosed the fact that the insurance is our only source of payment will we take an assignment on the policy.

It has been our experience that the employers will often cooperate with us when insurance policies are nonassignable and will see that our bill is paid.

Our admitting clerks are instructed to tell all patients supposedly covered by insurance, with the exception of Blue Cross plans, the policy of the institution in regard to these insurances. If they are unable to make the required payment covering the first week's room and board, they are referred to the credit manager who can go further into the matter of hospitalization insurance and the hospital's acceptance of that policy as a basis of payment.

The intensive effort that we make on the admission of a patient is extremely important because if a careful analysis of the patient's ability to pay and a definite plan for payment are not made, misunderstanding will develop and the account will be more difficult to follow up after discharge.

Patients and hospitals benefit by

Uniform Visiting Hours

KARL G. HAUCH
Acting Director
Chicago Hospital Council

IN ARRIVING at recommendations regarding uniform visiting hours to be submitted for approval by members of the Chicago Hospital Council, the committee was faced with the problem of what degree of uniformity was desirable. Strict uniformity would work a considerable hardship on certain hospitals that have definite reasons for starting their visiting periods half an hour earlier or later than their neighbors. These reasons may be based on nursing and other personnel schedules or schedules of meal preparation and serving, which presumably have been drawn up carefully as a result of necessity.

Not only would it require courage and hard work to change them but under present conditions any change might create serious personnel problems within the institution. It was also felt that in some hospitals the visiting arrangements were developed to meet conditions peculiar to the communities that these hospitals served.

It was decided, therefore, to make recommendations on the basis of maximum hours and maximum days per week that could be shortened to meet the needs of individual hospitals. At the same time the committee indicated that it favored as strict uniformity as possible by all member institutions.

A by-product of the program is a certain amount of curtailment of visiting. This curtailment is wise at this time because of the shortage of personnel coupled with a continued intensive use of hospital facilities.

After careful consideration of the data submitted and study of similar programs adopted in other sections of the country the committee agreed on recommendations for general adult, obstetric and pediatric services, each subdivided into private, semiprivate and ward accommodations.

No attempt was made to cover exceptions warranted by such situations as critically ill patients, visiting on day of operation or unusual working hours (as in the case of war workers). It was felt that special individual arrangements to meet such problems should be made by the administrator or his representative.

General Adult Service:

Private Rooms—One member of the immediate family from 10 a.m. to 9 p.m.; other visitors from 2 to 5 p.m. and from 7 to 9 p.m.; not more than two visitors during each period. These are maximum hours (daily), which may be reduced to meet the problems of the individual hospitals.

Semiprivate Accommodations (two or more bed rooms, private physician)—From 2 to 4 p.m. and from 7 to 9 p.m.; not more than two visitors during each visiting period. Again, these are maximum hours that may be reduced.

General Ward Accommodations—Visiting not to exceed a one hour period in the afternoon or evening of certain days designated by the individual hospital during the following periods: between 2 and 5 p.m., and between 7 and 9 p.m. No more than two persons during any one visiting period.

Obstetrical Service:

In general—visiting arrangements to be based upon regulations issued by the Chicago Department of Health for the conduct of maternity services.

Labor Rooms—Fathers only where practicable. One person may take the father's place if the latter is out of the city.

Delivery Rooms—No relative or visitor.

Exhibiting of Babies—Evenings only during the visiting period if evening visiting is provided for. If evening visiting is not provided, arrangements are to be made during the afternoon visiting period.

Visiting of Mothers After Delivery: Private Rooms—Husbands may visit from 3:30 to 5 p.m. and from 7 to 8:30 p.m. daily. Husbands may also be permitted a brief visit from 8:30 a.m. to 1 p.m.

Two visitors in addition to the husband may be designated each day by the patient and may visit once per day, either between 3:30 and 5 p.m. or from 7 to 8:30 p.m.

Semiprivate Accommodations—Husbands may visit from 3:30 to 5 p.m. and from 7 to 8:30 p.m. daily. Two visitors in addition to the husband may be designated each day by the patient and may visit once per day, either between 3:30 and 5 p.m. or from 7 to 8:30 p.m.

Ward Accommodations—Same as maximum hours for general adult accommodations, the days and hours to be set by the individual hospital. No more than two persons *including* the husband during any one visiting period.

Pediatric Service:

Visiting to be restricted to parents or guardians only.

On day of operation or for seriously ill children, mother may be allowed to stay with child by special permission.

In private rooms, parents may visit daily from 10 a.m. to 7 p.m.

In semiprivate accommodations, visiting is permitted daily but shall be limited to one hour between 2 and 5 p.m., the hour to be designated by the individual hospital.

In ward accommodations, visiting shall be limited to one hour per day, two days per week, the hour and the days to be designated by the individual hospital.

New Wing at METHODIST HOSPITAL Gary, Ind.

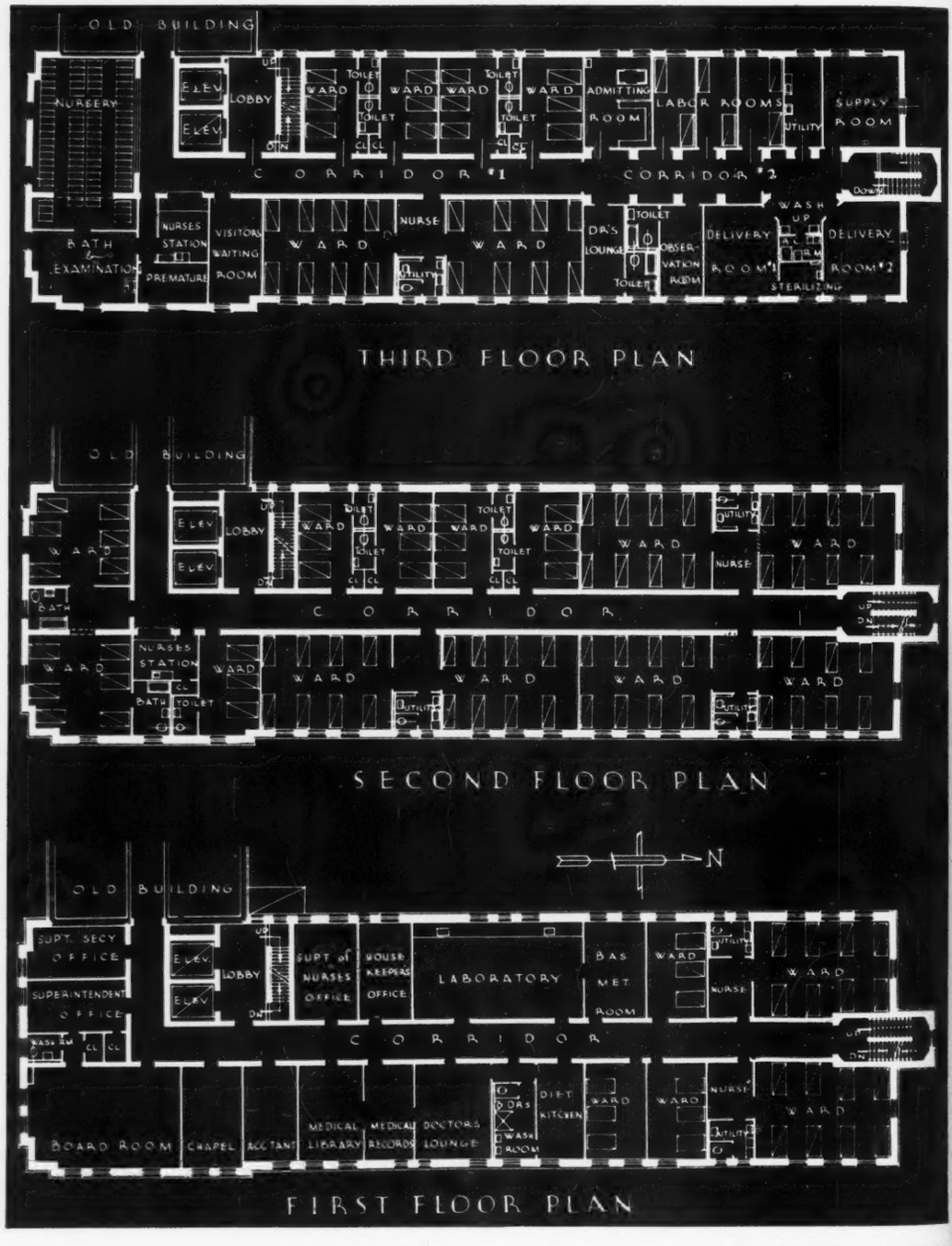
REV. JAMES LAWSON
Administrator
Methodist Hospital, Gary, Ind.

BEINE, HALL and CURRAN
Architects, Gary, Ind.

Above: Exterior of the new wing which gives the hospital 131 additional beds. Right, top: The obstetrical department occupies the third floor. The three labor rooms, with two beds in each, are decorated in pastel tints. Near the delivery room is a lounge fitted with a bed and comfortable chairs for the use of doctors.

Right, center: The second floor accommodates 75 beds in six and eight bed rooms. Each pair of the eight bed rooms is divided by a good-sized utility room containing sterilizer, sink, toilet and bedpan washer. The nurses' station commands a view of both corridors.

Right, bottom: The business offices, chapel, medical library and board room are located on the first floor in addition to two eight bed rooms.



CONSTRUCTION DETAILS

CONSTRUCTION: Brick and Indiana cut stone exterior conforming to existing building. Fireproof throughout. Precast concrete floor slabs. Interior partitions, gypsum tile. Wood window sash. Doors, wood and metal.

HEATING: Vacuum return steam system with supply through pressure-reducing valve from high-pressure boilers in main plant. Cast-iron radiators.

VENTILATION: Exhaust systems exhausting air from main kitchen and from nursery and toilet rooms.

LIGHTING: Fluorescent lighting in corridors, administrative offices and public spaces. Direct-indirect lighting in patients' rooms. Night lights in patients' rooms and corridors.

CALL SYSTEM: Call station at each bed and toilet with lamp at door and annunciators at nurses' station and at main nurses' station on each floor. Doctors' in-and-out register.

REFRIGERATION: Separate units provided for kitchen and kitchen storage.

LAUNDRY: Present laundry being enlarged to provide for additional load. Rebuilt washers, extractor and 120 inch six roll ironer being installed.

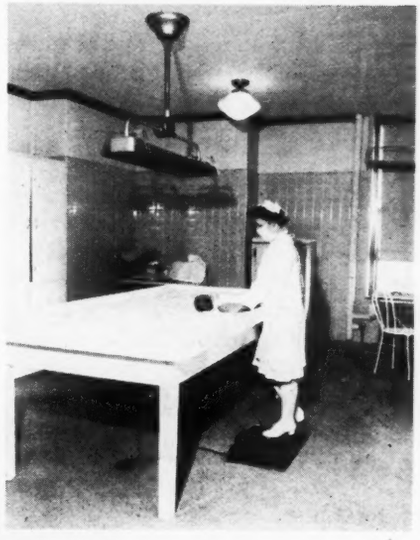
WALLS: Ceramic glazed structural blocks in entire basement section. Ceramic tile wainscoting in all baths, toilets, delivery rooms, utility rooms, wash-up, nursery, examining room and premature nursery room.

FLOORING: Terrazzo base and floors over the entire floor areas except kitchen where quarry tile was used.

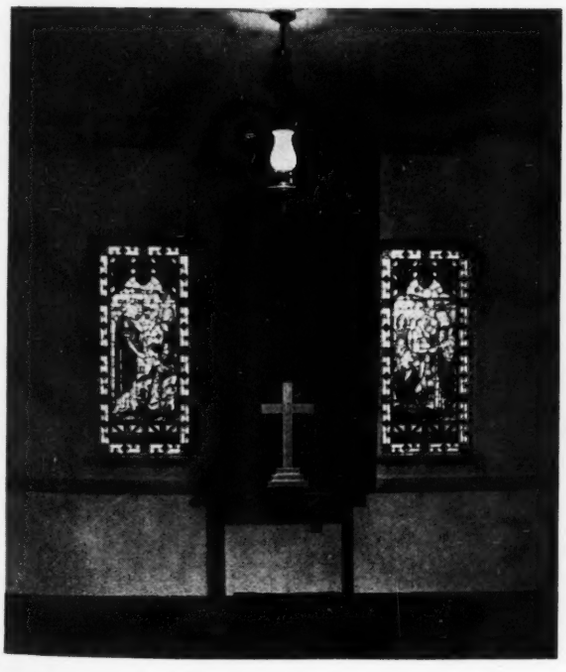
CEILINGS: Acoustical in all areas except kitchen, food storage and stair halls.

KITCHEN: Fully equipped with gas ranges, refrigerators, cooling rooms, dishwasher, food warmers.

COSTS: Total building cost including plumbing, heating, ventilating and electrical, excluding land, equipment and architects' fees: $296,000, divided as follows: building, $215,848; heating, $16,140; ventilating, $3850; plumbing, $17,312; wiring, $26,750. Volume, 441,225 cubic feet. Cost per cubic foot, $0.603. Architects' fees, $16,100.



Above: A proud father gazes at his son in the new blue-tiled nursery. Ultraviolet lamps sterilize the air over his crib. On the right can be seen one of the outlets through which oxygen is piped up from the basement. Left: The bathing room connected with the nursery. While the nurse stands on the treadle the ultraviolet light is shut off and when she steps off it the light is automatically turned on. Below, left: The little chapel was furnished by members of the Jewish, Catholic and Protestant faiths. Below, right: Nurses and students line up to be served in the colorful basement cafeteria.



Seven steps toward saving

Adhesive Plaster

EDNA H. NELSON

Administrator
Women's and Children's Hospital
Chicago

SURGICAL adhesive plaster is perishable. Rigid control of distribution and proper storage are necessary to avoid serious deterioration.

Every year hospitals are obliged to absorb losses on adhesive plaster running into thousands of dollars.

Adhesive plaster for surgical use is made with a rubber base, which accounts for its perishable nature. All manufacturers have been required by the government to limit the rubber in the adhesive plaster mass. However, the quantity of rubber allowed is considered sufficient to meet the average need.

Ordinarily, hospitals do not buy adhesive plaster far ahead of their needs and most experienced storekeepers are careful to store it in a cool dry room as is necessary to assure retention of adhesive qualities.

Also, the informed storekeeper is usually careful about storing adhesive plaster chronologically. Older stocks should be so placed in the storeroom that they will be sent to the various departments before new shipments are distributed.

Store Adhesive on End

All rolls of adhesive plaster should be stored on end and not horizontally. When rolls are laid flat the pressure on the sides of the roll, over a period of time, will make the plaster more difficult to unwind, especially the last few feet on the roll.

Despite these precautions, in many well-regulated hospitals one can find some adhesive plaster that was manufactured three years previously.

When a hospital has trouble with adhesive plaster it is usually brought to the attention of the administrator or purchasing agent by one of the department heads who has experienced the trouble. Quite naturally, on receipt of such a complaint, the administrator assumes that this department has received the adhesive from the storeroom within the last thirty days or so. However, in many instances a careful check may disclose that the particular adhesive plaster has been stored in the department for several years. This fact is often proved by the findings of adhesive plaster manufacturers. Often, when adhesive plaster is returned with a complaint on the most recent shipment, the manufacturer reports that, included in the return, are rolls of adhesive plaster that were made several years previously.

Assuming that the average hospital has organized its storage system so that plaster is kept properly and that the manufacturer knows definitely that all shipments of plaster from his factory or branch warehouses are of recent manufacture, why is it that many hospitals should have on hand, somewhere in the institution, plaster that is two, three or more years old?

A manufacturer's sales representative ordinarily calls on 200 or more hospitals in his territory and is responsible for checking up on all complaints received through the superintendent or buyer. When a complaint is registered with him, his routine procedure is somewhat as follows:

1. He examines all stock in the department that made the complaint to determine whether the plaster is of current manufacture or from old stock.

2. If any plaster is more than a year old, he examines all stock in the storeroom to determine the date of manufacture of all stocks on hand.

3. If no old plaster is found in the storeroom, it would indicate that the complaining department had at one time requisitioned from the storeroom more adhesive than it could use in a long time. Or, as is frequently the case, the department might have unearthed a few old rolls that had been stored for some time in an out of the way place where they have remained unnoticed.

In order to clear up some complaints completely, it may be necessary to check carefully every closet, cabinet and other possible storage space in every department in the hospital. In a sizable hospital this might require the greater part of a day, with a resultant loss of time by both key members of the hospital staff and the salesman.

If adhesive plaster is stored away and lost from circulation in this manner, isn't it possible that rubber goods and other valuable supplies that deteriorate with time might also be misplaced and represent a substantial loss to the hospital?

Suggestions for Conservation

To correct this situation the following suggestions are offered:

1. The subject should be discussed at meetings of the hospital staff, professional and lay.

2. When no central surgical supply department now exists, the important saving made possible by the establishment of such a department should be brought to the attention of the board of trustees with a recommendation that such a department be created at the earliest date possible.

3. Lacking a central surgical supply department, the storekeeper should be given definite instructions as to the maximum of perishable goods that may be requisitioned at one time by each department. Each department should give the storekeeper an estimate of its requirements of such supplies for thirty days.

4. Each department requiring storage space should designate the exact place for this purpose. The department head should be held responsible for keeping such reserve supplies in this designated place only. A periodic check should be made to keep the supply at a minimum.

5. The hospital should make a rule that no perishable supplies may be stored in cabinets or table or dresser drawers. Adhesive plaster should be stored upright on shelves in plain view, easily accessible, where it will not become lost behind other supplies.

6. A careful study should be made of the sizes of cut adhesive plaster

used in the various departments in the hospital. If little used sizes should be sent in large quantity to one department, some of them may stay in that department more than a year before they are used.

The following are the approximate percentages of cut sizes of adhesive plaster used in the average hospital: ½ inch, 15 per cent; 1 inch, 20 per cent; 2 inch, 40 per cent; 3 inch, 20 per cent; 4 inch, 3 per cent; all others, 2 per cent.

Manufacturers supply 12 inch by 10 yard rolls of adhesive plaster, either cut all one width on the core or in standard assortments. As a rule, it will be found that it is easier to keep balanced stocks by ordering only the rolls containing one width, rather than those with assorted widths. When rolls of assorted widths are distributed to the various departments, it is probable that these rolls will contain some cut sizes for which the department may have little or no use.

7. Each department head should make a semiannual inventory of all perishable goods in storage in his department, together with an estimate of the length of time this stock should last.

CONSERVATION
calls for salesmanship

STUART HUMMEL
Administrator
Silver Cross Hospital
Joliet, Ill.

CONSERVATION during war time of personnel, labor and supplies of all kinds is not only a patriotic duty of all who are in hospital work, it is an absolute necessity.

Our first job in the conservation of personnel is to go back to the depression practice of making careful studies of all working units within the hospital to determine the actual number of employes required. Personnel and job studies often result in finding alternate ways of performing a given task in a more economical and efficient manner.

We must conserve ability to do a given task for that type of task alone. Most hospitals have resorted to using nurse's aides, nurses' station secretaries, more students, volunteer help and older employes to meet shortages in personnel.

Unnecessary trips to the storeroom, the central service room, the front office and other parts of the hospital must be reduced to a minimum. Waiting at mealtime for cafeteria or dining room doors to be opened and for food service must be eliminated along with similar evidences of inefficiency that have an insidious way of creeping into any organization.

Waste of linen increases the already overburdened laundry organization. The spilling of liquids and careless handling of waste paper and flowers all increase the work load for the housekeeping department.

Considerate interdepartmental cooperation must be developed to its greatest extent in the hospital today if we are to surmount our personnel problems during these difficult war years.

Proper maintenance of elevators, dumb-waiters, room doors, crank springs, laundry and kitchen equipment has a most important part in saving time for personnel. If we can find the small inefficiencies within our organizations the larger ones have a way of being corrected automatically.

Conservation of supplies is also a patriotic obligation and a financial necessity. Increases in the cost of certain supplies and shortages of others require a real reduction in the use of those supplies. The goods we save in the operation of our hospital make just that much more available to our armed forces and to our allies.

To save supplies takes more than just a resolution on the part of the administrator to talk to the department heads. Like the selling of war bonds to the public, the idea of conservation of supplies must be sold to every person in our hospital family. Properly organized, the job should not be difficult for, to begin with, each person to whom we are to sell our determination has a sincere desire to be a good patriot.

Employe committees to study the problem of supply savings, possibly prizes offered for the best ideas, personal letters to employes from the superintendent all will do more to accomplish the desired savings than will penalties for breakage.

The surgery and service room staffs can work out means of eliminating excessive heat sterilization of rubber goods and a further standardization of dressings and catgut supplies.

The pharmacist and nursing personnel can jointly arrange for closer checks on floor medicine supplies through smaller stocks and more accurate inventory control. The pharmacist should be encouraged to increase the manufacturing activities of the drug room.

Shortages in rubber goods and other commodities should not be kept like state secrets in the purchasing office but should be made known to all employes.

As administrators we have a golden opportunity presented to us to direct the patriotic desires of our personnel toward the savings that are now so vitally necessary. This spirit of patriotic saving and a consciousness of the importance of that saving must be developed in our organization through a selling effort rather than by critical comment or threat. In no other way can we hope to lead the way to supply savings and greater personnel effort.

Excerpts from address to the American College of Surgeons war conference.

About People

John R. Mannix, director of Michigan Hospital Service since its organization in 1939, has been appointed executive director of the Plan for Hospital Care, Chicago, effective April 1. He succeeds **Frank A. Denniston,** who has taken the position of executive vice president of the American Health Insurance Corporation of Baltimore.

During his period with the Michigan Blue Cross organization, Mr. Mannix brought this organization up to the second largest membership of all Blue Cross plans. From 1930 to 1939 he was assistant director of the University Hospitals of Cleveland. From 1926 to 1930 he was superintendent of the Elyria Memorial Hospital, Elyria, Ohio, and prior to that was associated with Mount Sinai Hospital, Cleveland, under the late Frank Chapman.

Mr. Mannix is a charter fellow of the American College of Hospital Administrators, is vice chairman of the Hospital Service Plan Commission, a member of the editorial board of The MODERN HOSPITAL and a past president of the Ohio Hospital Association.

He will continue to serve as director of Michigan Hospital Service on a part-time basis until a successor is chosen.

Administrators

Dr. Edgar A. Bocock, who resigned as superintendent of Gallinger Municipal Hospital, Washington, D. C., on March 4 assumed his new duties as administrator of Doctors Hospital, Washington, and superintendent of the entire medical center of which the hospital is a part. Doctor Bocock succeeds **John A. Lindner.**

Paul Dufault, former assistant superintendent at Rutland State Sanatorium, Rutland, Mass., has been named superintendent of that institution.

William T. Hardaway has been selected to head the Veterans Administration Facility, Tucson, Ariz., succeeding **Dr. Samuel H. James,** who is now manager of the Veterans Administration Facility at Outwood, Ky.

Dr. W. C. Reineking recently accepted the position of superintendent of Morgan County Tuberculosis Sanatorium, Jacksonville, Ill. He was formerly head of Alexander County Tuberculosis Sanatorium at Cairo, Ill.

Dr. Herbert T. Wagner, whose resignation from Stuart Circle Hospital, Richmond, Va., was reported last month, has been named superintendent of Meriden Hospital, Meriden, Conn.

Jane M. Boyd, for the last five years superintendent of Homeopathic Hospital of Chester County, Chester, Pa., will become superintendent of Butler County Memorial Hospital, Butler, Pa., on April 15. Miss Boyd was assistant superintendent and director of nurses at Butler in 1936-37. She is a member of the Philadelphia, Pennsylvania and American hospital associations and a nominee of the American College of Hospital Administrators.

Ernest R. Snyder, who has been acting superintendent of Elmhurst Community Hospital, Elmhurst, Ill., for the last year and a half, was appointed superintendent at the last meeting of the hospital board of trustees.

Elwin E. Glover has been appointed superintendent of Brooks Memorial Hospital, Dunkirk, N. Y. For the last fifteen years, Mr. Glover was associated with Buffalo General Hospital, Buffalo, N. Y., in various capacities, including credit manager and office manager.

Michael Levine has been appointed assistant director of Montefiore Hospital, New York City. Mr. Levine is an authority on plant cancer and is president of the Torrey Botanical Club. He was associated with the high schools of New York City for many years.

T. J. McGinty has resigned as assistant superintendent of Missouri Baptist Hospital, St. Louis, a position he has held for the last three years. He has accepted an appointment with the Baptist organization of Florida and will build and operate a 150 bed hospital in Pensacola, Fla. Mr. McGinty served as president of the Midwest Hospital Association in 1938 and has just concluded a year's work as president of the Missouri Hospital Association.

Lester E. Richwagen of Barre, Vt., who was formerly Vermont director of the War Production Board, recently assumed the duties of superintendent of Mary Fletcher Hospital, Burlington, Vt.

Charlotte Dowler, R.N., formerly superintendent of nurses at King County Hospital, Seattle, has joined the staff of the new Doctors' Hospital, Seattle, with the duties of assistant administrator.

Richard Highsmith, administrative assistant at Evanston Hospital, Evanston, Ill., has been appointed assistant administrator at Oak Ridge Hospital, Oak Ridge, Tenn., working under **Dr. William Holt.**

Dr. Sigmund L. Friedman has resigned his position as assistant director at Montefiore Hospital, New York City, to become assistant director at Beth Israel Hospital, Boston.

Lt. Joseph W. Bishop is now serving at the Station Hospital, Fort Dix, N. J. Before joining the Army, Lieutenant Bishop was assistant administrator at Polyclinic Hospital, Harrisburg, Pa. He is a graduate of the University of Chicago course in hospital administration.

Jane M. Belknap, R.N., has resigned as superintendent of Henderson Hospital, Henderson, Ky., to accept a similar post at McAllen Municipal Hospital, McAllen, Tex.

Harold B. Burr, business manager, **William B. Forster,** purchasing agent, and **Edwin W. Miller,** pharmacist, all of City Hospital, Akron, Ohio, have been appointed assistant administrators at that hospital, it was announced on February 24.

Marie Anderson, for the last two years superintendent of Northfield City Hospital, Northfield, Minn., has resigned. **Inez Lewison** has accepted a temporary appointment as superintendent.

Ruben C. Idstrom, assistant superintendent of Swedish Hospital, Minneapolis, has been chosen to succeed **Mrs. Hilda M. Gedny** as head of Rice Memorial Hospital, Willmar, Minn. Mrs. Gedny served as superintendent of Rice Memorial from its opening in August 1937 until March 1 of this year.

Dr. N. Stanley Lincoln, since 1936 medical superintendent of Mount Morris Tuberculosis Hospital, Mount Morris, N. Y., has been transferred to a similar position at Hermann M. Biggs Memorial Hospital, Ithaca, N. Y., succeeding **Dr.**

(Continued on Page 146)

The Public Knows "There's a War On"

Here are some of the criticisms that are most often leveled at war-time hospital service by a reasonably understanding public

EDWARD KIRSCH, M.D.

Assistant Director
Jewish Hospital, Brooklyn, N. Y.

THE war has had, and will continue to have, a marked effect upon our hospital personnel, and the problems that have arisen have served to focus our attention, with ever-increasing concern, on hospital service and on those available to perform it. Hospitals have lost many of their trained, conscientious employes to the armed forces and to war industries.

The shortage of manpower is such at the present time that we have been forced to lower previous high standards and to accept the inebriated, the disinterested, the inexperienced and the unintelligent, many of whom we considered unemployables in normal times.

Keeping Them Is the Problem

Coupled with the problem of securing employes is that of keeping them. The rapid and consistent turnover of personnel has made training on the job a difficult task in spite of the more intensive training programs in vogue today. Results have not been entirely satisfactory and evidence of hurried and incomplete training may be detected in the conduct of certain of the newer employes.

With the decrease in the number and the efficiency of employes, and with the inevitable change in the quality of service, it was anticipated that comments to this effect would be made by patients, relatives, visitors and others.

It is interesting to note that few complaints have been received from patients or from relatives on behalf of the patients. Most criticism has been received from visitors and members of the staff. This may be due in part to the fact that the services that have been partly curtailed or altered have been those that do not affect the patient directly. It is also interesting and instructive to note the variety of comments that have been received.

The Public Expects Courtesy

The community has been taught to expect certain services and facilities and has come to associate courtesy and exemplary behavior on the part of hospital employes (even under the most trying conditions) with hospitals, just as it associates immaculate cleanliness with such institutions. It is, therefore, not surprising that the recent unavoidable deviation from the usual behavior and normal high standards has been considered as strangely out of place in a hospital environment.

Comments from visitors and relatives fall into several categories. Perhaps the greatest number concerns the lack of courtesy on the part of the new type of hospital employes, to whom courtesy entails a new and strange relationship between individuals. Abruptness, surliness, ill-temper, disinterestedness and downright rudeness are greatly resented by those who experience such treatment.

Accusations of discourtesy are most frequently lodged against the newly engaged telephone operators, elevator operators, admitting office clerks, cashiers, information desk clerks and, occasionally, against doctors, nurses, maids, orderlies and porters.

No matter how short of help we may be, how rapid the personnel turnover, how inefficient or harassed the employe—courtesy should be insisted upon at all times. Department heads must explain to new employes that patients and relatives are often fearful, worried and emotionally upset and as a result may not be as polite, tactful and reasonable as they should be in their requests for service. Allowances must be made for the state of mind of these individuals.

It should be explained to each new employe that the first impression of the hospital may be obtained from him and that upon his actions depends whether this impression will be favorable or unfavorable. Booklets stressing the need for courtesy on the part of all hospital personnel should be distributed to new employes.

Department Heads Set Example

Department heads must emphasize the need for courtesy and every breach of etiquette should be brought to the attention of the offender. Needless to say, department heads should set the example in their dealing with the employes themselves and in their contact with others.

Failure on the part of hospital employes to give necessary and accurate information is another frequent cause for comment. New members of the admitting and accounting offices are sometimes at fault in this respect.

There is so much routine work to be remembered and performed, and the volume of work may be so great, that recent additions to these staffs occasionally do neglect to give as much information to the patient or his relatives as they should. They do not appreciate the fact that what is commonplace to them may be quite unfamiliar to others.

It is imperative that those who assume responsibility for the hospi-

talization of a patient be informed as to types of accommodation, rates, possibility of additional charges, possibility of transfers, visiting hours and regulations, disposition of personal belongings and all other matters that are essential to the proper understanding by the family of hospital procedures.

It is a common error for new employes to fail to realize that patients and relatives may have had no previous experience with hospital routine, that they are emotionally disturbed and that they expect to be given instructions—not to have to ask for them. Much ill will and unnecessary trouble can be avoided if employes give all available information to patients and visitors and give it as concisely, as simply and as graciously as possible.

Booklets Are Helpful

Many hospitals use booklets or printed forms to convey information concerning rates, accommodations, visiting hours and other hospital data. At times a new employe may neglect to hand out these printed forms. Strict supervision and constant correction of errors are required to avoid this cause for complaint.

Written procedures to be used as a guide for employes in the various departments are of specific value in this regard if used properly. The admitting and accounting offices have been mentioned primarily, but other departments, such as the information desk and the telephone office, have also been at fault in this respect.

Any employe who comes into contact with the public should be aware of the reason for the contact and should strive to make it as profitable and as pleasant as possible for all concerned.

Closely allied to failure to give sufficient information is the giving of misinformation. Relatives and visitors sometimes relate that they have been misinformed, misdirected or misled. Misinformation is worse than no information at all, as it requires much effort to dispel mistaken notions and to explain and rectify errors. It is embarrassing for one hospital employe to have to contradict another and to have to apologize for the carelessness or inefficiency of another. Those who receive incorrect information frequently receive an incorrect impression of the hospital organization.

New employes must be cautioned against giving any information unless they are authorized to give it and capable of giving it. If there is any doubt as to the authenticity of information, the employe must check with his department head or colleagues or refer the matter to the appropriate office.

The general inefficiency of certain employes is also cause for dissatisfaction. The inept elevator operator, the inexperienced telephone operator, the hesitant information clerk, the flustered, ineffectual admitting clerk are all targets for criticism and resentment. The poor delivery of mail, flowers or gift packages is noted and remarked upon by those who have been inconvenienced. The occasional loss of clothing or other belongings is another valid cause for complaint against careless employes.

Most people today make allowance for deficiency in efficiency. They are aware not only of the general curtailments in service but also of the underlying causes. There are some, however, who apparently do not realize the causes or who do not wish to make allowances for them and they are not loathe to give utterance to their impression that hospital service "is not what it used to be."

The decreased tempo of certain service is also discussed by visitors and relatives. Inexperienced employes naturally are not as alert, discerning and nimble as the more experienced. Long waits at the cashier's window, in the admitting office or at the information desk annoy the impatient. Slow elevator or telephone service is also exasperating to some people.

The record room and the accounting office have come in for an unfair amount of criticism. Former patients in large numbers are now requesting statements and abstracts from the hospital. Income tax exemptions and selective service requirements are responsible for this unusual demand upon record room and accounting department facilities.

As hospital patient loads have generally increased and as many hospital departments are understaffed, it has been a real hardship to produce requested material on short notice or even within a reasonable length of time.

Not only have members of the community been taught to expect swift, efficient and courteous service but doctors, nurses and other personnel have also become accustomed to smoothly functioning routines. It is not too unusual to hear criticism from members of the visiting intern or nursing staffs concerning facilities that they utilize.

The main targets are the elevator and telephone services, the admitting office, the dining rooms and even some of the departments concerned with the clinical investigation and treatment of patients. Members of the medical and nursing staffs often criticize in others the shortcomings they themselves exhibit but of which they are apparently unaware.

It is advisable for the administration to keep these groups informed of current conditions, personnel problems, food and rationing situations and other relevant matters. Periodic discussions, adequate explanations and constant attempts at education may convert many uninformed knockers into intelligent, well-informed boosters.

Nursing Service Not Criticized

It is gratifying to note that there has been practically no increase in complaints from patients concerning medical and nursing care. Whatever slight curtailment of service has been necessary has been accepted. The shortage of doctors and nurses is well known to the public, and people are now becoming conscious of the problems associated with food rationing, shortage of materials, rising costs of living and the general dislocation that occurs in time of war. They are becoming more patient, more tolerant and more cooperative.

The fact that comments have been made about present day service is an indirect tribute to the hospital. The hospital provided an excellent, well-rounded service when it was able to. Now, through circumstances over which it has no control, service has altered somewhat in quality and the public has been quick to notice the contrast.

People are becoming aware of the reasons for this state of affairs, however, and are discovering that the hospital is doing a good job under adverse conditions and in the face of many obstacles. Both the public and the hospital look ahead with confidence to the day when once again hospital service will be just as efficient, courteous and exemplary as it ever has been.

The Ethics of Medical Records

Prepared by the Conference of Professional Problems of the Cleveland Hospital Council

MATERIAL contained in medical records is a "privileged communication" and as such is confidential between the patient and the physician.

Hospitals are, therefore, both legally and ethically obligated to protect that information from the eyes of the curious. Hospital records are furthermore the property of the hospital; therefore the institution may rightfully promulgate and adopt rules and regulations governing the procedure of exhibiting such records.

Information that is not considered privileged and is available to any individual on request includes the following:

Complete name of patient.

Address of patient (as given at time of admission).

Verification of his hospitalization.

Admission and discharge dates.

Name of relative or friend given on admission.

The Rest Is "Privileged"

Any other information, including age, address on discharge, if to a sanitarium or state hospital, the service on which the patient was hospitalized and all professional information, is considered as "privileged" and may not be disclosed without proper authorization to the institution.

Disclosure of the names of physicians associated with the management of a case may best be considered from the practical standpoint. The name of a physician, while technically not privileged material, may be considered as such, and there is apparently no legal compulsion for its disclosure except in court. However, it is usual and customary to disclose the names of attending physicians *with their permission.*

Disclosure of the names of house officers should be considered carefully inasmuch as they are agents of the institution, which is liable for their acts. In addition, they may be unlicensed, and their call to court for testimony brings up this complicating factor.

Professional information from medical records is usually sought for one of six purposes, namely:

1. Assistance in diagnosing and treating a patient's disease.
2. Investigation of insurance claims or applications for insurance.
3. Settlement of medico-legal cases and the preparation of evidence in connection with legal procedures.
4. Idle or malicious curiosity.
5. Research and study.
6. Assistance to medical-social agencies in their program.

In consideration of these factors the following procedures are suggested:

1. Doctors or institutions requesting professional information in writing or in person and indicating clearly that the patient involved is at that time under their care are entitled to any information they request, subject to these regulations:

In the case of a private patient, professional information is given only with the permission of the previous attending physician.

No professional information is given over the telephone except in cases of definite emergency. In such cases, the name and telephone number of the physician are taken and checked in the directory and the call is returned.

In rare cases in which a patient has requested that no information be given, it will be necessary to have the patient's written consent to give information to a physician or institution.

Professional information is not given to a federal institution without written authorization from the patient.

Professional information is not given to employers or company physicians without written authorization from the patient.

2. Professional information is given to insurance investigators verbally or in writing only upon receipt of written authorization from the patient and with permission of the attending physician, if it is a private patient. No insurance investigator, physician or layman is permitted to see the medical record. No information is given over the telephone.

3. Professional information is given to attorneys under the same regulations as those governing insurance investigators.

4. Records are taken into court upon receipt of a regulation court subpoena. Such subpoena should be accompanied by the established fee and it is the right of the person receiving the subpoena to demand this fee. If the fee is not forthcoming, the subpoena may be disregarded without consequences. What subpoena should be answered depends on the issuing court.

Where Subpoenas Are Valid

The federal courts have the power to subpoena witnesses from any of the states of the United States and its territories. The common pleas court may subpoena from its own and adjacent counties. Municipal courts and justice courts may only subpoena within the county in which they are located. The validity of a notary's subpoena to a deposition depends on whether proper notice has been given by the one seeking the information to the opposing party's counsel and should not be answered without confirmation by the attorney for the patient.

Records taken to an attorney's office in compliance with a notary's subpoena should be exhibited only in the presence of the attorneys representing both parties to the litigation.

5. Professional information is given to no other persons except in case of written request from the patient and when the reasons for seeking information can be shown clearly and are valid. No information is given to a patient from his own record. He is referred to his physician for answers to his questions. This ruling applies when the patient is himself a physician. Professional information is given to staff patients only by authorized staff physicians.

It is recommended that the procedure prepared by a joint committee of representatives of the Cleveland Hospital Council, the Academy of

Medicine and the Cleveland newspapers be followed by the hospitals in making available information relative to patients.

Proper Authorization for Release of Professional Information:

Authorization signed by a person since deceased is not valid.

Authorization should be witnessed and, in theory, should be notarized. This latter seems unnecessary in cases where there is no reason to doubt the validity of the signature but may be demanded if desirable for any reason.

Authorization dated prior to the dates of the record in question is not valid.

Photostatic copy of authorization may be acceptable, if otherwise satisfactory. It is suggested that notarization be included in all these.

Authorization in case of a deceased patient follows the usual custom of authorization for necropsy, namely, spouse (unless divorced), parents, children, siblings, more remote relatives and friends. The authority of an executor of an estate should be recognized upon presentation of due proof of appointment.

Police officers acting in official capacity should be given information upon request, unless this request is unreasonable. They should be requested to sign a statement of the purpose of their investigation and the information they desire.

Any authorized agent of the Industrial Commission of Ohio is authorized to review any record without permission of the patient, provided the patient is an industrial case.

It is believed that information may safely be given to selective service boards without authorization, inasmuch as the selective service board has the power to subpoena records.

The Physicians Certificate Bureau of Attendance, Cleveland Public Schools, Form A-11, may also be filled out for staff patients without authorization.

Regulations Governing Use of Medical Records for Study:

1. Medical records are lent by the medical records department on the same principles as books are lent by a public library.

2. Records may be borrowed for a period of two weeks. If work is not completed at the end of this time, a renewal for two more weeks may be obtained on request.

3. A maximum of 20 records may be borrowed in one group. A second group of 20 may be obtained upon the return of the first group.

4. If possible, studies of hospital records should be carried out in the record room.

5. Never, under any circumstances, is a record permitted to leave the building except in the case of a subpoena to produce it in court or in a notary's office for a deposition.

6. Students wishing to review records must bring permission slips signed by their instructor. They are not permitted to take records from the department.

7. Any doctor who borrows records and does not conform to these regulations loses the privilege of borrowing records for a period of three months.

Information Provided to Social Agencies:

Upon request, interpretative information of assistance to the agency may be provided—usually by the corresponding agency within the institution. Medical information is provided only upon receipt of valid authorization and is addressed only to a physician.

Photostatic Copies:

Photostatic copies of medical records may be made and should be exhibited only after compliance with all of the rules concerning valid authorization for the release of professional information. If the photostatic work is done off the premises, the record should be under the supervision of an authorized record clerk at all times and returned at once to the institution.

Recommended Charges for Transcripts and Information:

The subcommittee recommends that uniform charges be made for the provision of medical information.

1. It is recommended that no charge should be made for information that is available in the business office.

2. Copies of discharge summaries from hospital records, $1.

3. Complete or partial transcripts of hospital or out-patient department records, $2 per hour.

4. Charge for time spent by record room personnel in reading charts to attorneys, investigators or other persons authorized to obtain information, $2 per hour.

5. A charge of $2 is recommended for time required in answering a notary's subpoena if this is undertaken at all.

Liaison Between Medical Record Department and Collection Department:

It is recommended that close working relationships between these two departments be effected so that collections may be enhanced. The advisory committee to the central investigation service recently recommended:

"The member hospitals should adopt a procedure whereby the person in the record office would be required to advise the business office that a request has been received for a 'Certificate of Proof of Death.' Upon receipt of such information by the business office from the record office, it would be the obligation of the business office to determine whether satisfactory arrangements had been completed for payment of the account and, if such arrangements had not been completed or the account had not been paid, it would then be the obligation of the business office to discuss the matter with the person requesting the 'Certificate of Proof of Death' in order to protect the interests of the hospital by arranging for payment of the account.

"While it is recognized that this procedure will not in every case result in collection, it will provide a method that will better protect the hospitals than if such practice were not followed. When such a procedure does not result in collection a reinvestigation may be requested of the central investigation service."

The subcommittee suggests that all correspondence relating to the care and management of patients might well be cleared through one central point. The establishment of this facility would enable an institution to effect the closest possible liaison between collection officers and other departments of the institution that might acquire information of interest in collection procedures.

In lieu of a central agency, the development of a routing procedure for correspondence might be established. This routing procedure might function by directing that all correspondence in connection with requests for information should be cleared through the accounting office, either as incoming or as outgoing mail, and the approval of the latter office be given before information is released.

ESCAPE!

Navy Nurses learn about "lung training"

ENSIGN E. R. McDONNELL
U. S. Navy Nurse Corps

Official Navy Photographs

Nurses "go below" to take instruction in the use of the diving bell.

HAVING heard interesting accounts about the "lung training" activities at the submarine escape training tank on our station, U. S. Submarine Base, New London, Conn., a group of Navy nurses visited that department one Saturday afternoon to observe the training process. What we saw through the observation portholes that day made us want to try it, but we never dreamed we would have the chance.

However, the officer-in-charge remembered our enthusiasm and one day sent word that he would be glad to train any nurses who were interested. Ensign G. E. Huckstep and I volunteered. There remained then only one problem, finding the time to fit it into our schedule.

So, one Saturday afternoon, on our "day off," we were on our way to the beach but stopped off at the tank to arrange a time for our training and Lieutenant Burton, the officer-in-charge, offered to give us our swim and training right then and there.

First, we had to be "conditioned" for our adventure by being enclosed in a large air-tight cylinder and subjected to approximately 50 pounds of air pressure. Our instructor carefully explained how to equalize the pressure—that this increased air pressure might hurt our ears unless we closed our mouths lightly, squeezed our nostrils and blew hard. We practiced this a few times, then agreed we were ready to go.

The heavy round steel door was clanged shut and secured and presently the loud hiss of the incoming compressed air drowned our conversation. At first nothing happened, then a sharp pain in the ears and our instructor's voice, raised now to a shout, reminded us to "equalize," but soon clearing our ears became automatic and the rising temperature (which actually shoots up to 120° F. in a few minutes) made us forget about our ears.

We began to watch the pressure gauge on the wall and as it approached the 50 mark, we were very uncomfortable. It felt as if we were breathing fire. We knew now why the streams of perspiration had literally run off the men when we were watching through the peep-hole the day we were observing.

We went "topside" in the elevator, and the view up and down the Thames River from this vantage point in the glass-enclosed space above the 100 foot column of water which is the training tank was breath-takingly lovely. There we were taught how to use the "lung" and received our "ladder" training. You see, there are ladders in position at the edge of the tank and the trainees stand on the rungs of the ladder while they get the feel of breathing through the "lung." Then they climb down the ladder until their heads are just under the surface of the water and practice breathing in this position.

When the instructor was satisfied that we understood the working of the "lung" (which is worn suspended from the neck by a strap and looks something like a brief case with a vacuum cleaner attachment reaching up to the mouth and nose), we rode down through the water for a distance of 12 feet in the bell and came up on the line from that level.

The bell is an ingenious cage-on-a-cable arrangement that can be operated up and down the cable at will. An observer stationed in this bell keeps watch over the trainees making all ascents and in case of any difficulty can pull them into this compartment, where the air pressure is maintained at sufficient height to keep out the water from the tank and maintain an air pocket in which to breathe.

We repeated this trip because, with true Navy thoroughness, the instructor requires that two ascents be made from each level. Then we were ready for the next grade in our underwater education process. We rode down the outside of the tank in the elevator to the 18 foot lock. The door was secured and the compartment flooded up to the level of the door entering into the tank itself, which process (we were assured) compressed the air sufficiently to hold back the water of the tank when the inner door was opened.

Sure enough, the magic worked. In we went and up the line, comfortably and uneventfully to the surface again. Oh no, you don't climb up the line, you simply hold it within your loosely clasped hands and lightly pressed between your feet and let yourself lift slowly upward. The effortless, slow-motion glide with the shower of bubbles rushing up ahead of us was really fun.

The process was repeated once more from the 18 foot level and twice from the 50 foot lock. The experience was much the same, just that our upward trip was a little longer. We took turns being "first" but whether first or second you could feel the line move and knew that your companion was just ahead or just behind you.

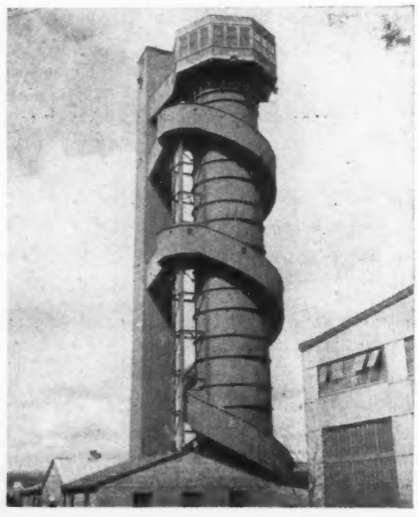
We were so enthusiastic at our success at this point that we were eager and anxious to make the 100 foot escape on the same afternoon and thus earn the coveted diploma decorated with replicas of the famous mermaidens that grace the side walls of the tank. However, there are several reasons why this is not permitted on the same day and the volunteers for the 100 foot escape (no one is required to make it) return on a second day.

Accordingly, we were on hand bright and early on the following Saturday afternoon. We had to repeat our "pressure cooking," of course, but we were veterans by now and experienced no difficulty.

This time we were to start from the chamber that is directly beneath the tank itself. We stood ankle deep in the water; the water-tight bulkhead was secured, a few turns on a big valve started the water flooding in.

It had been explained to us that when the water reached the level of the "skirt" that is, the replica of an actual escape hatch on a submarine (which looks like a big pipe), it would stop flooding in and would leave us an air pocket in which to breathe. When the water reached our waists we began to wonder . . . but everything worked according to predictions.

The instructor blew oxygen into our "brief cases," we adjusted our mouthpieces and nose clips; then, we were ready to go. We had to duck down under the "skirt" and there in front of us was the line leading to the surface.



You clasp the line lightly and let yourself glide upward slowly. At intervals there are markers (like large beads) where you pause and take five full breaths before going on.

While you pause there you have time to admire the rich green color of the water and the froth of white bubbles that race up ahead of you.

As long as you remember to go s-l-o-w-l-y, all is well but if you get scared and come to the surface fast, holding your breath, the pressure (which is three times that of outside) will expand the lungs and force air into the blood stream and that could be fatal.

For this reason a medical officer is always standing by in order to render prompt treatment in case anyone gets panicky and comes to the surface too rapidly. Sometimes this does happen but owing to prompt and efficient medical treatment there has never been a fatality.

An instructor in goggles swam past now and then, looking and swimming like some bug-eyed creature of the deep, keeping watchful check that all was well with us. The color of the water grew lighter and lighter and presently we were back at the surface—topside again!

Topside, where willing hands assisted Ensign Huckstep (who didn't know how to swim) out of the water; coffee and congratulations were awaiting us.

We had thoroughly enjoyed our new experience and did not realize until afterward that we were the first women ever to have made the 100 foot simulated submarine escape.

The certificates testifying to our successful descent into the realm of Neptune and that we did "acquaint ourselves with the sirens of the deep in their boudoir and did, by diligent use of line and lung, escape 17 fathoms to the surface" were autographed by the officers of the tank and presented to us with due ceremony. The appropriate entry was placed in our health record.

Two of our fellow nurses, Ensign H. J. Glod and Ensign M. L. Cook, were sufficiently intrigued with our reports of this training experience that they followed our example and have recently completed their "lung training," with equally pleasant and successful results.

GOING UP! Men trainees at the submarine station escaping from a 16 foot bell. Above: Exterior of the tank in which escape training is given.

Psychiatry Belongs in the Program of cadet nurse training

WILLIAM C. SANDY, M.D.

Director, Bureau of Mental Health, Department of Welfare, Pennsylvania

WHILE the Bolton Act establishing the U. S. Cadet Nurse Corps has been functioning with increasing adequacy for the benefit of general hospitals, the shortage of personnel continues to be a safety and health hazard in the mental hospitals. Therefore, the opportunity of providing psychiatric training as a part of the cadet nurse program should appeal to all mental disease hospitals able to qualify under the Bolton Act and the federal regulations, for it should mean additional personnel of a high type.

The prevalence of psychiatric complications in both civil and military experience is still not sufficiently realized or understood. Even in civil life, fully 50 per cent of the medical and surgical cases have mental complications, ranging from mild emotional disturbances to more severe reactions that may seriously retard recovery and otherwise prolong illness or hospitalization unless they are recognized and appropriate treatment is instituted.

Nervous tension, anxiety and other types of psychiatric disabilities form almost as high a percentage of the casualties in the armed forces. The rapid screening of selectees at the induction centers fails to eliminate many candidates who may be so constituted that they cannot withstand the terrific strain of modern warfare. Many of these men could not have been spotted as potential neuropsychiatric cases even if a much longer period of examination had been possible.

Problems Are Not Understood

A better understanding by the general public of such psychiatric complications is needed. This is also true of some line officers in the military forces, a striking and distressing example of which was recently reported.

Even medical officers and practicing physicians and surgeons are likewise not too well informed, and there is only a limited number of psychiatrists available for military service. Therefore, training centers have been established for the medical officers and neuropsychiatry is receiving greater emphasis in the medical schools.

Comparatively few nurses have had psychiatric training. Some of the larger mental disease hospitals have had undergraduate nursing schools. Through affiliation with general hospitals during the training period, graduates of the mental disease hospital schools have qualified as registered nurses and they have ably demonstrated the value of their psychiatric experience.

Within the past few years, there has been a trend toward the discontinuation of such undergraduate nursing schools and the establishment of affiliation courses of three months or more in the mental disease hospitals for nurses under training in general hospitals. In other words, it was the conclusion that the basic training was more logically the responsibility of the general hospitals.

Under this arrangement, nurses who are sufficiently interested in psychiatry and wish to become qualified for leadership in that field are likely to continue their mental disease hospital experience on a postgraduate basis. As a consequence, there is a growing popularity of such affiliation courses. State boards of nurses are deluged for information regarding the availability of such opportunities.

In view of the broad psychiatric field, the shortage of informed personnel and the urgent need for it, the desirability for the psychiatric training of all nurses is evident. Hence, the importance of the plans for mental disease hospital affiliation during the cadet nurse corps training. While at the hospital, student nurses will observe and study under supervision the various types of psychiatric cases.

The result will be a more tolerant and understanding attitude on the part of the nurses toward the sick. Thereafter, whether in private practice, hospital or military service, nurses thus trained will naturally observe the whole patient and will not be so likely to neglect complications that might be overlooked by the less experienced.

Hospitals Will Benefit, Too

Such training is no less important for the mental disease hospitals. Over a period of years, it has been impossible to meet the demands of psychiatric institutions for qualified individuals to assume supervisory or teaching positions. This program, with the further postgraduate training of interested nurses, should develop qualified persons for these attractive positions of responsibility and leadership.

In the student nurse training program there are three classes of cadets. The precadet class includes the student nurses during the first nine months of the training period. After completing this period satisfactorily, the students then become junior cadet nurses and remain in this grade from fifteen to twenty-one months, until the required period of combined study and practice is completed, when they are termed senior cadet nurses.

The optimum time for psychiatric hospital affiliation is within and toward the end of the junior cadet nurse period. There is general agreement that such affiliation should be for not less than three months. The junior cadet nurses will have reached such a mature stage of theoretical training and practical experience as to enable them to profit best from their psychiatric experience.

Some senior cadet nurses may become available for assignment to mental disease hospitals for the re-

maining period of their training. It is the opinion of many directors of nursing, however, that senior cadet nurses should not be accepted for service in such hospitals unless they have already had psychiatric affiliation training.

In order to qualify for affiliation under the cadet nurse corps program, mental disease hospitals must meet certain minimum requirements, including approval by the appropriate accrediting agencies. They must also maintain a sufficient educational staff; must provide well-equipped classrooms and other appropriate facilities, and must furnish satisfactory living quarters and student health service.

Even some of the larger mental disease hospitals may find it difficult and perhaps impossible to conform to the requirements for affiliation. Particularly necessary is adequate housing for the student nurses, not luxurious, but a comfortable and sanitary environment, such as is found in standard homes for nurses. Adequate facilities cannot usually be furnished within a hospital building but should be located apart, providing the necessary relaxation.

The patriotic and ambitious young women accepted for training under this program are entitled to the special consideration of superintendents, directors of schools and medical staffs. They may have entered training after a hurried decision and after sacrificing former plans of long standing, possibly resulting in personal problems of adjustment.

The efforts of these students should be met not with thoughtless criticism but with understanding encouragement, especially in hospitals in which the principles of mental hygiene should be practiced.

Send Waste Paper to War!

WILLIAM M. SCANLAN
District Salvage Chief
Chicago District Office
War Production Board

WASTE paper, which in peace time was so plentiful that it became a nuisance in the hospital, today is a vital war material. The demand is so great that normal trade channels are unable to supply enough waste paper to keep mills running full time and to enable them to meet all overseas and home-front war requirements. By February 26 approximately 25 paper mills had been shut down for lack of waste paper and inventories are dangerously low in many others. The situation is critical.

Today, the W.P.B. regional offices throughout the country are asking for the cooperation of every hospital, every doctor and every medical and dental unit in the scrap paper program. These institutions are asked to dispose of books, magazines, newspapers, records, wrappings, cartons, advertising literature and bulletins. They are asked to ferret out every last scrap or shred of paper to go into the salvage paper drive.

Literally tons of old hospital records are being thrown into the scrap pile. Old medical records of a confidential nature are being gathered together, bound up and delivered to the shredding machine.

Typical of the hospital response is that of St. Luke's in Chicago, where Leo Lyons, director, is today supervising the task of microfilming all the records for the last forty years and tossing the original records into the scrap heap. Microfilms form a more nearly permanent and safer record, and at the same time sufficient floor space is being conserved to permit new locker rooms for employes and additional bed space.

Microfilm machines can be rented from local sources, the names of which are available from the local W.P.B. office.

Microfilming of old records is only one step, however. Each hospital head should also check the following sources of waste paper: old files, ledgers, correspondence, receipts, canceled checks, time cards, invoices, pamphlets, calendars, bulletins, obsolete catalogs, books and periodicals, containers, flower boxes and wastebaskets.

Used paperboard containers are particularly in demand and the large number that come into hospitals regularly should be carefully conserved and turned back for reuse. Corrugated and solid fiber containers and setup boxes should be carefully collapsed, tied into bundles and turned over to a scrap or container dealer.

A hospital may handle paper and other salvage in one of two ways: (1) contract with a salvage dealer to collect, handle and dispose of all the hospital's salvage at regular intervals or (2) itself collect the salvage, bale, bundle or shred it and dispose of it direct to a dealer or mill. Both paper balers and shredders can be obtained today and hospitals seeking to purchase them should consult the local W.P.B.

There are four immediate steps that should be taken to accelerate at once the waste paper collection.

1. Appoint and hold responsible some member of the hospital personnel to head and correlate the paper salvage program.
2. Take immediate steps to scrap old records by using microfilms.
3. Publicize the waste paper drive with bulletins or posters in every department, with short talks and appeals to personnel.
4. Set up a system of waste paper collection with every possible source of waste paper checked at regular intervals.

No waste paper should be burned until it is ascertained that it is not recoverable for war use. In cases where there is a question as to the disposition of confidential papers and records, the W.P.B. office should be consulted for information as to how this material can be recovered.

Hospitals can be especially helpful in the waste paper drive by publicizing the campaign to all doctors. Their offices are fruitful sources of old magazines, newspapers, bulletins and records.

For the Records

Methods of handling medical records in 17 small hospitals

THE advent of war has compelled changes in small hospital medical record procedures, many of which will doubtless be counted as long-run gains.

The principal change is that hospitals have decided to give more aid to physicians so that they can keep up their medical records. They have employed medical stenographers (when they could) and provided dictating machines at convenient locations.

Another significant change is that small hospitals now look with much more favor on the microfilming of their records so as to save precious space needed for other purposes.

Seventeen hospitals replied to the inquiry sent out to 50 small institutions. The first set of questions asked was: "How can small hospitals persuade physicians to write up their medical records? What assistance should be provided to them? What penalties for negligence have proved effective?"

Numerous Aids Offered

Eight hospitals report that they have provided a medical secretary to take dictation and thus enable the physician to complete his records promptly and with greatest economy of time. Other aids mentioned include: provide convenient rooms for dictation where privacy is possible; put "every facility" at the disposal of the physician; have interns write records and doctors sign them; provide dictating equipment, and have medical records librarian go to the operating room for dictation before and immediately after the operation. One administrator reports that "constant pounding" was necessary to obtain medical records. Three others stress personal contacts. Three say they do not know how to convince the physicians.

Penalties have not been beneficial in two of the reporting hospitals. Most others report some success. Three hospitals state that the medical record committee of the medical staff calls delinquent doctors "on the carpet."

Five hospitals will not admit any more patients of a physician who is inexcusably delinquent with his records. Two fine the delinquent doctors 10 cents or 25 cents for each delinquent record. One states that it attempts to "create pride in the physicians in having their records up to date."

One lists all of a physician's delinquent records in sending him a notice of the staff meeting. Two others read to the medical staff meeting the names of doctors who are behind schedule in their records.

Dorothy Mathews of King's Mountain Memorial Hospital, Bristol, Va., tells how this hospital caught up with its problem. "Last year we were somewhat in arrears with the records. On July 1 the resident physician's term expired and we have had none since that date. The physicians in this hospital, as a whole, are quite record conscious but a few were in arrears. It was necessary to take it to the executive committee which set a deadline when those delinquent records must be completed.

"The record problem was somewhat solved by the following: I was able to employ a middle-aged woman who is an expert stenographer but knew nothing of medical terminology. She consented to try this new position as a medical secretary.

"A former records librarian came in for a week or ten days and helped her establish her office, assisted her and gave her a form to use. Her office is the former resident's sitting room on the same floor as the x-ray, laboratory, operating rooms and delivery room. All physicians reach this floor at some time during the day.

"Each morning the secretary gets the names and locations of patients admitted after 4 p.m. the day before and is notified by telephone of any new admissions. She takes each physician's dictation of history and physical examination at the bedside or in her office. The busy physician will drop in, smoke a cigar or cigaret and dictate the progress notes. By this system the completed chart reaches the record room earlier than it did when we had a resident physician.

Situation Best in Five Years

"The records librarian takes up from there, checks the record and gets the physician's signature. I believe our record situation at the moment is the best it has been in five years."

At St. Catherine's Hospital, Kenosha, Wis., Sister Bertrund, records librarian, reports the following procedures:

"We have found the following successful: (a) providing dictating equipment which is available to the doctors day and night; (b) having the records librarian go to the operating room both before and after operations to obtain the history and operative notes; (c) listing on each doctor's notice of a staff meeting the number of his incomplete records, and (d) reading the names of doctors who are delinquent at the staff meeting.

"Our most effective penalty for

THANKS TO THESE CORRESPONDENTS

Hospital	Respondent	Beds
Sheldon Memorial Hospital, Albion, Mich.	Forst R. Ostrander	40
McRae Hospital, Corinth, Miss.	W. H. McRae	50
West Nebraska Methodist Hospital, Scottsbluff, Neb.	Rev. John B. Bucknell	50
Kings Mountain Memorial Hospital, Bristol, Va.	Dorothy Mathews	57
Bath Memorial Hospital, Bath, N. Y.	Helen Dumack	60
Baker Memorial Sanatorium, Charleston, S. C.	Ida M. Dwight	60
Bozeman Deaconess Hospital, Bozeman, Mont.	John A. Sivertsen	65
Frasier-Ellis Hospital, Dothan, Ala.	Jewell W. Thrasher	66
Appalachian Hospital, Johnson City, Tenn.	Vesta L. Swartz	70
St. Catherine's Hospital, Kenosha, Wis.	Sister Bertrund	70
Wentworth Hospital, Dover, N. H.	Katherine C. Hall	85
Reynolds Memorial Hospital, Glendale, W. Va.	Ruth M. Stultz	90
Woodstock General Hospital, Woodstock, Ont.	Helen L. Potts	100
St. Agnes' Hospital, Fresno, Calif.	Sister M. Sylvina	100
Deaconess Hospital, Grand Forks, N. D.	O. H. Overland	110
Canonsburg General Hospital, Canonsburg, Pa.	Edward J. Milsom Jr.	116
Memorial Hospital, Easton, Md.	Ray Brooke	140

negligence was a 10 cent fine for each record not completed within thirty days after the patient had been discharged. Even though this has been discontinued for the present because so many doctors have left for the armed services and the rest are overworked, the good habit of coming in to clear up unfinished records before the monthly staff meeting has continued."

Katherine C. Hall, administrator of Wentworth Hospital, Dover, N. H., describes her system concisely:

"Our records librarian meets each doctor as he enters the hospital and acquaints him with the fact that she is free to assist him in making any records he may desire. The head nurse on each ward asks all doctors for their progress notes every week. We are constantly checking with the doctors on this.

Barred From Sending Patients

"My suggestion for penalties is: after asking the doctor for his notes three times, if his records are not done, his name should be brought before the medical staff meeting. If he still refuses the help of the librarian and does not do his records himself, he should be barred from sending patients into the hospital."

A different point of view is expressed by Helen L. Potts of Woodstock General Hospital, Woodstock, Ont.:

"We find it does not help to demand. The doctors are not unwilling, but it is so easy to put it off until another day unless they are constantly reminded of their responsibilities. We provide a nurse with stenographic training who is responsible for checking incomplete records and is also available for dictation. We have never invoked penalties and would consider them of little value in the average hospital."

Sister M. Sylvina, superintendent of St. Agnes Hospital, Fresno, Calif., reports that the mere existence of a rule barring doctors from practice in the hospital if records are incomplete is usually sufficient. "We have had occasion to enforce this only once; since then the doctors have completed their charts before the deadline."

Asked whether hospitals of 100 beds or less should employ a medical records librarian, the response was almost overwhelmingly in favor, fourteen to three. Of the three that dissent, one states that it cannot afford a librarian but that the American College of Surgeons says it should. One of those in favor suggests that the librarian could combine her work with some other job if she has any time left over.

On the employment of a medical stenographer, there is less unanimity. Seven say yes, four, no, one says "only if no resident or only one resident is available" and two declare that the medical records librarian should also serve as stenographer (as indeed many do).

"In my opinion a hospital is not fully staffed unless it has a medical records librarian," states Forst R. Ostrander, Sheldon Memorial Hospital, Albion, Mich. On the other hand, W. H. McRae of McRae Hospital, Corinth, Miss., feels that "with decreased personnel and government agencies taking all your help away with more pay and frozen wage scales, it just can't be done."

"If a comparison must be made, we have always maintained that medical records librarians are of more benefit to the small hospital than to the large one," according to Jewell W. Thrasher of Frasier-Ellis Hospital, Dothan, Ala.

"There is more than enough work in the small hospital to keep a full-time records librarian employed," reports Sister Bertrund. "The American College of Surgeons practically bases its rating of the hospital on the quality of the records. Good records, complete as to quantity and quality, are in great measure up to the records librarian as well as the doctor."

Some Changes Made

The hospitals were asked: "What changes in medical record procedures have you made during the war period?" In addition to the items previously mentioned the following were noted by one or more hospitals: briefer records for the duration; two yearly reports eliminated (diagnosis and physicians referring patients); reduced nurses' bedside notes and earlier discontinuance; all forms checked to eliminate duplications and unnecessary data. One of the most unusual adjustments has been made by Canonsburg General Hospital, Canonsburg, Pa., whose records librarian now works in a defense plant in the daytime and at the hospital in the evening.

On the length of time that records should be kept there is considerable variance of opinion. For the clinical record itself, eight hospitals report that it should be kept indefinitely, one says for a hundred years; two, for fifteen years; three, for ten years, and one, for not over two years.

Because of the increased need for proof of place of birth to obtain jobs and for other reasons many hospitals are finding old medical records of great assistance to former patients.

Only four of these hospitals keep nurses' notes indefinitely. One keeps them for fifteen or twenty years; four, for ten years; one, for five years (but longer in accident or compensation cases); one, for two years, and

one, for one year. One keeps them only until the patient is discharged and one states that "it is not necessary to file nurses' notes but we do it anyway."

Only one hospital reports that it keeps x-ray negatives indefinitely. One keeps them for fifteen or twenty years; six keep them for ten years; one, for six years; two, for five years; one, for three years, and one, for one year if the film is diagnosed and recorded. One hospital keeps chest x-rays indefinitely but not other types.

In "Legal Guide of American Hospitals," Hayt and Hayt state that "in a cross-section study of hospitals it was revealed that the majority kept their records permanently. From this study the conclusions were reached that medical records should be kept permanently if there is adequate space; old records should be abstracted on cards before being destroyed; nurses' notes may be destroyed after ten years; records should be kept or photographed, especially until after the statute of limitations has passed."

Because of the storage problem of records, the hospitals were asked their opinion of microfilming as it applies to the small hospital. Six report that they think it is practical for small hospitals and eight do not think it is practical, at least now when there is a shortage of personnel. One is doubtful about it. One hospital reporting this idea as now impractical hopes to microfilm its records after the war.

"We are microfilming all our records of the last twenty years," reports Supt. Edward J. Milsom Jr., superintendent of Canonsburg General Hospital. "The cost per year is about the same as files and folders would cost and the space saved is worthy of much consideration."

Most of the hospitals transfer their records from the active to the inactive file within one year. One waits for two years; another waits "a few years"; two wait for five years. One says it depends upon the diagnosis and another that it depends upon the "storage pressure."

Those who are interested in noting trends in the operation of small hospitals will find a similar inquiry on records in The Modern Hospital for March 1941. The results of this present inquiry may profitably be compared with the earlier data.

WOMEN'S SERVICE GROUPS

First State Organization?

Representatives of 15 women's auxiliaries in eight cities of Texas met with the Texas Hospital Association on February 23 and 24 in Dallas to form the first state-wide section on hospital women's auxiliaries of any state hospital association. At least this was the claim of the women present. There have been province-wide organizations of women's auxiliaries in Canada for some time but apparently none in the United States.

Naturally, as with any new organization, there was considerable discussion regarding the details of the organization, how it should be governed, how it should vote and similar matters. All such questions were settled in due course and a full slate of officers elected. The delegates were greatly stimulated by executive secretary George P. Bugbee of the A.H.A. who told them that America's hospitals would hardly have been able to function without the aid that women have rendered on a volunteer basis.

The auxiliaries represented were: Mercy Hospital Auxiliary, Brownsville; Fred Roberts Memorial Hospital Auxiliary, Corpus Christi; Bradford Memorial Hospital Auxiliary, Women's Auxiliary of Dallas City-County Hospital System, Women's Auxiliary of Dallas Methodist Hospital, Richmond Freeman Memorial Auxiliary, Women's Scottish Rite Auxiliary, all of Dallas; Harris Memorial Methodist Hospital Auxiliary, Fort Worth; Houston Negro Hospital Auxiliary, Women's Auxiliary of Memorial Hospital, Women's Auxiliary of Methodist Hospital, all of Houston; Women's Auxiliary of Christ the King Hospital, Vernon; St. Joseph Hospital Auxiliary, Wellington; Bethania Hospital Auxiliary and Women's Auxiliary of Wichita General Hospital, both of Wichita Falls.

Miss Powell's Pin

Emma Powell, volunteer extraordinary, can well rest on her laurels. Or, to be more specific, she can now rest under her laurels. For after 24,000 hours of volunteer service to Children's Memorial Hospital, Chicago, Miss Powell has gone—not to her reward, for she had her reward as she went along; rather, Miss Powell has gone to rest.

Miss Powell did not choose to rest as long as she was alive. A few years ago she had an accident following which she could not walk without crutches. But neither crutches nor advanced years stopped Miss Powell from giving the 100 hours a month she had donated to the hospital since 1924. Until the last week of her illness, early this year, she kept up her hospital work.

What did Miss Powell do during those twenty years? She organized the filing system in the social service department and the record room. She set up the filing system in the department of photography. She organized the reference library of the social service department. She worked in each of these departments as the needs required.

Whether they buried with Miss Powell the Della Robbia bambino pin presented her by the woman's auxiliary board for her service, nobody could tell us. Maybe her pin is being preserved for the next volunteer who gives 24,000 hours to the hospital.

Opens New Shop

The woman's board of Presbyterian Hospital, Chicago, opened a gift shop shortly before Christmas and the shop has been gaining in patronage steadily. Big sellers are the hand-knitted baby sweaters, bonnets, blankets and shawls and the scarves, pincushions, belts and caps woven by the Berea Student Industries of Berea College, Kentucky.

Other items handled include greeting cards, stationery, cosmetics, books, toiletries, gum, cigars and cigarets. Arrangements have also been made for taking orders for flowers, with deliveries from the florist once each day.

No food is served in the shop as the hospital recently opened a cafeteria where staff, employes and visitors are served at four regular meals. The cafeteria is open twenty hours a day.

Proceeds from the recent tag day, held annually by the woman's board, amounted to $2517, a gain of $347 over the previous year's collection.

In Chicago, tag days are restricted and Presbyterian Hospital gets 10 locations on the Children's Benefit League tag day. The foregoing amount, therefore, will be used entirely for the free bed fund for children.

Nine teas have been held for the new maternity endowment fund and these have netted $1650 thus far.

In the Big Money

The famed fashion show held annually by St. Luke's Hospital, Chicago, netted $25,500 this year. This show and the annual benefit given by Passavant Hospital are the two largest money raisers sponsored by women's boards in the Middle West. Passavant's 1943 "paper party" was described by The Modern Hospital's Roving Reporter on page 6 of the February issue.

TRUSTEE FORUM

CONDUCTED BY RAYMOND P. SLOAN

With an Eye to the Future

JOSEPH C. DOANE, M.D.
Medical Director
Jewish Hospital, Philadelphia

NOW is the time to begin work on a postwar program. If community peace-time need has been proved, if decisions are not based on boom-time conditions and if estimates from past experiences will guarantee maintenance, let us proceed with our plans. In planning that postwar program it is well to remember that tomorrow:

1. Volunteers will be greatly reduced, if not completely absent, and paid personnel must replace them.
2. Government subsidies for training nurses or for conducting blood banks will cease and corresponding expenses will begin.
3. Rate cards may have to be scaled downward.
4. Blue Cross plans may be embarrassed by governmental competition.

How Will the Hospital Look?

What will the postwar hospital look like? No doubt the same arguments for multistoried or detached building plans will continue. Some hospitals of today rise far skyward. Others seem to be constructed with the idea that walking is good for nurses, patients and physicians.

There is little doubt that glass and composition material that is semi-opaque will find its way into future construction more than in the past. One may visualize shining hospital structures with thinner walls but with heat-retaining and light-transmitting properties that today would be considered fantastic.

Perhaps our growing knowledge of the reaction between sunlight and skin cells in the production of vitamins may favor such structural policies. There is little doubt that utilitarianism will be strongly evident. Less extravagant corridor widths with less waste in height of wards and rooms may reduce cubic footage requirements.

From a talk before the American Hospital Association, Buffalo.

Of great interest are developments in air sterilization in nursery, maternity and surgical wards. It is not beyond the bounds of reason to anticipate the development of a system whereby built-in pipes will only require the turning of a valve to spray the air with chemicals harmless to patients but lethal to bacteria.

Even now a molecularized chemical solution is being used by the armed forces which, marketed in cylinders under pressure, destroys in a few seconds that scourge of the tropics, the malarial mosquito, as well as flies and similar insect life.

Perhaps the external appearance of the hospital will not experience such radical postwar changes as may be envisioned for its furnishings and equipment. It has been a healthy experience to learn of our own possibilities in doing without.

Heretofore, the hospital administrator and the visiting staff have been wont to conclude that materials and supplies employed in yesterday's treatment of patients are absolute essentials for the technic of today. Indeed, it was with a feeling akin to panic that the future was faced with priorities on instruments, rubber goods, steel furniture, sterilizers, refrigerators and other equipment. Restrictions on certain drugs, such as quinine, were viewed with alarm. These changes, however, have only served to recreate a resourcefulness that is much to the credit of hospital workers.

These are no days for fair weather administrative sailors. It may be truthfully said, however, that no patient has suffered as a result of any war-time restrictions in supplies. Loss of trained personnel has been the chief reason why the public has rightfully complained of inadequate hospital service.

It is questionable whether those high in federal authority have considered the hospital as the essential public utility that it is. Any policy that has as its basis "anything is good enough for the voluntary hospital" bodes ill for the present as well as the future of that institution.

The future no doubt will continue to prove that there is a vast difference between the essentials and the luxuries in hospital equipment and supplies.

Striking innovations will surely creep into the manufacture of equipment.

Air Conditioning a "Must"

It is highly probable that in two decades hospitals that are not fully air conditioned will be considered antiquated. No longer will the public tolerate the practice of operating upon patients in superheated rooms, thus adding to the incidence of dangerous circulatory derangements observed postoperatively. Illness in summer should not of necessity be complicated by the torture of heat and humidity.

Refrigeration systems will probably be less cumbersome, more efficient and less expensive. If an airplane can be air conditioned, less complicated refrigeration for the hospital should certainly be perfected so that long and expensive brine-lines with too frequently leaking ammonia valves no longer exist.

Soundproofing developments promise much. Hospital corridors and rooms reverberating with the conversation of nurses and the slamming of doors, not to mention the presence of factory-like delivery and labor rooms, will be no more.

Lighter, stronger materials will find their way into the construction of hospital beds, tables and movable equipment. Instruments of stainless steel should be less expensive. From $5 to $10 for a hemostat will in postwar times appear gross extravagance.

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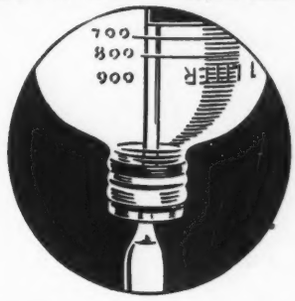

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Here, again, it is wholly likely that the trend in hospital equipment will be toward simplification in construction and the lessening of expense.

Of equal or even greater importance to the hospital field will be the financial policies of the future. Some of us believe that the free and untrammeled spirit of the voluntary hospital can still persist and continue to render its contribution to the public by treating all patients of all economic levels through cooperation with Blue Cross plans.

Socialization of the hospital field, in the opinion of many, can only bring restriction of effort, a great burden of official forms, reams of red tape and growing interference by power-hungry politicians in the admission, treatment and discharge of patients. To be sure, the complicated structure of taxation now existing and every day being expanded in this country will have a deterring effect on the creation of trust funds and the granting of private endowments.

Nevertheless, while this tendency, begun a half decade ago, has now become a reality, yet the voluntary hospital continues to perform its functions by the use of funds largely gained by augmenting its own earned income. The voluntary hospital, assisted, perhaps, by a greater service to the indigent by state and county institutions, does not and will not need the paternalistic interest of a federal system which for many years has increasingly entered into competition with the voluntary institution.

How will the postwar hospitals be staffed? Again, we are alarmed to read the text of a bill that proposes to place community doctors, whose recompense is regulated by federal statute, under the supervision of a governmental official. It is difficult to understand the motives behind such a move, or is it? Here again, the autonomy of voluntary hospital administration is threatened. Unless boards of trustees continue to have full power of selection of hospital personnel, morale and efficiency will surely suffer.

Finally, what of that less concrete structure which we know and recognize as the institution spiritual? For buildings, like the human body, house the soul—the indestructible purpose—that composite of unselfishness and untiring striving which vitalizes each true hospital worker. Will the hospital of the future measure its success solely in terms of red ink or black? Will the soul of the body grow tired of the continual refusal of many to realize that buildings and instruments but make the physical body that houses the soul of the hospital?

Members of boards of trustees must in the last analysis decide the issue. When the finger of politics beckons there is but one decision to make. It is the trustee who must proclaim that nothing but that which is proved beneficial must approach the patient's bed. It is the trustee and the trustee only who can successfully raise his voice against sham and chicanery in high and low places when these threaten the welfare of the sick.

If the doctor and nurse are high priest and priestess in the Temple of Aesculapius, it is the trustee who is the Olympian in whose temples they labor.

I Know a Man

CHARLES H. YOUNG, M.D.
Superintendent, Stamford Hospital, Stamford, Conn.

I KNOW a man who has retired from business and is apparently leading a happy life. I know others who have retired from business and are existing unhappily. These did not realize until too late that retirement usually means retirement from personal contacts, from social life and from nearly everything that formerly made life interesting and pleasant.

For a time they attempt to visit but soon are made to understand that they are taking up the time of active busy men and have little to contribute in return.

This man I know, however, has the means and has learned the ways of inducing or compelling others to give him a service that contributes to his happiness.

Some years ago, before retirement, he donated a large sum of money to the suburban hospital in his residential town and was made vice president of the board of trustees. He has held this office ever since, refusing the presidency. A more descriptive title would be the "controlling spirit of the hospital," for he has, ever since his munificent gift, dictated the policies and controlled the practice of the institution.

After retiring from business, he took on other activities that occupied his time for a while and furnished a by-pass for his restive spirit. His associates in these activities did not wholeheartedly accept the inconveniences of his aggressive personality and he soon found himself eased out, with time on his hands and many ideas in his alert mind.

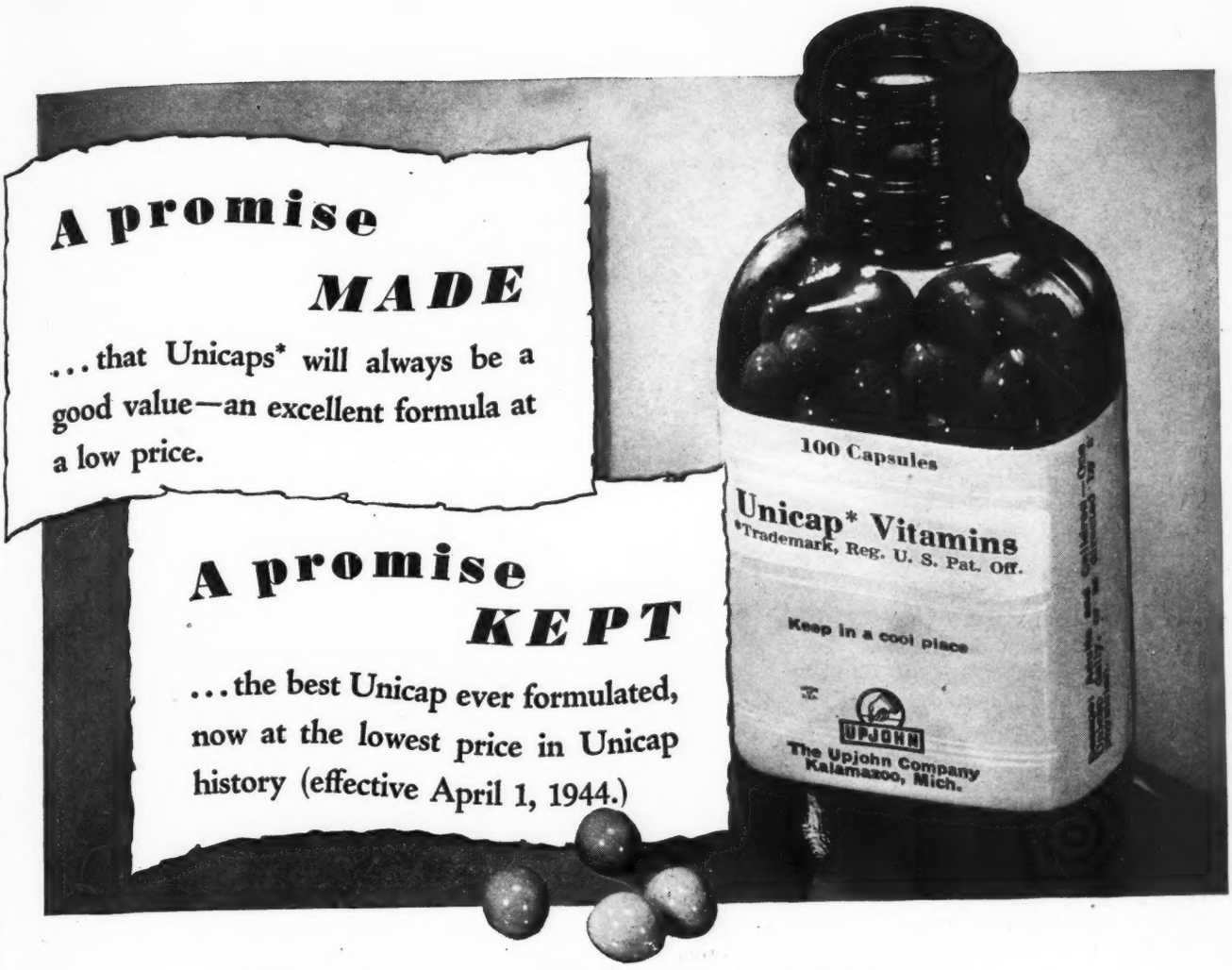
So he began to come to his hospital more frequently and, for a time, was useful and welcomed. But in his case, as in others, time passes on and senility creeps along with it. For several years now he has spent nearly every morning in the hospital and wanders over it, department by department.

Mornings are busy times for department heads, but all other duties must be laid aside in order to give the service of time and attention to this one man. He is thought of, by many, as a Nice Old Man, for he attempts to please everybody and hospital people can often get things through him that have been refused by the so-called administrator.

From this administrator down, the hospital is staffed with yes-men and yes-women, for the old man is supposed still to possess much money, and he can't live forever, and the hospital needs endowment.

So the octogenarian still continues to dominate the hospital's affairs, and the hospital goes on hoping that peace will be restored with his passing and contentment will be once more established in its professional and executive staff through the money which it is hoped that the old man will bequeath.

Maybe this is all that it should be, but I hope I pass out before people begin to think of me as a Nice Old Man, a Public Pest and a Private Nuisance.



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—Geriatrics Series—

Tuberculosis Strikes at the aged, too

J ARTHUR MYERS, M.D.

Professor of Internal Medicine, Preventive Medicine and Public Health, University of Minnesota

AT PRESENT there probably is no greater incidence of pulmonary tuberculosis among the aged than when the twentieth century began. However, there has been such a marked decrease in the prevalence of this disease in the earlier decades of life that the problem among older persons now stands in bold relief.

The present situation is due, in part, to differences in the incidence of infection with tubercle bacilli at various ages of life. The tuberculosis control program in this country has been directed largely toward the protection of human beings against infection with tubercle bacilli of both the human and bovine types. The veterinarians and their allies have so completely controlled the disease among the cattle herds that it is now a rarity for a person to become infected from cattle.[1]

Situation Is Reversed

The construction of sanatoriums and the establishment of tuberculosis services in general hospitals have provided for the removal of large numbers of tuberculous patients from their homes and communities. The recent recognition of the extreme contagiousness of tuberculosis has caused a considerable percentage of the public to avoid contact with persons who have this disease in communicable form. These factors have played an important rôle in almost completely reversing the situation with reference to the incidence of tuberculous infection among the persons in the earlier decades of life.

Instead of finding the majority of young adults infected with tubercle bacilli (by the tuberculin reaction), as we formerly did, in many parts of this country we now find the majority uninfected. Among 73,000 college students tested in 1942 only 21.8 per cent were infected.[2] Indeed, there are now numerous entire counties in this nation in which among the senior students in high school not more than from 5 to 8 per cent have been infected.[3] Obviously, if the present infection attack rate is maintained in such counties, not more than from 20 to 30 per cent will be infected at the average age of death.

Already there is good evidence that the infection attack rate is decreasing in these counties and if the decrease continues the time is not far distant when the tuberculin reactor among young adults will be uncommon.

It is only the tubercle bacillus that causes tuberculosis; therefore, there is no tuberculosis problem among the uninfected. On the other hand, every tuberculin reactor, regardless of age, is a potential case of clinical tuberculosis. Obviously, the lower the incidence of infection, the fewer the clinical cases.

Among the persons of this country of 45 years or older, one still finds a fairly high incidence of tuberculous infection, as manifested by the tuberculin test. When such persons were young, almost nothing was done to protect them against tubercle bacilli. Tuberculosis was rife among the cattle herds, pasteurization was not generally practiced and few escaped infection with the bovine type of tubercle bacillus. Tuberclosis among human beings was not considered very contagious and the number of patients isolated in sanatoriums and hospitals was extremely small.

Therefore, most persons with clinical tuberculosis in communicable form remained in their homes and communities until they died, spreading tubercle bacilli to their contacts. Thus, few persons escaped infection. Many of the infections contracted in those days have persisted and are now present in the bodies of persons of 45 years or older. Each one of these persons is a potential case of clinical tuberculosis.

Harvesting the Crop of Neglect

Obviously, therefore, there is more clinical disease developing among them than among other persons of the younger generation, in whom a relatively small number is infected. Indeed, we are now reaping a part of the harvest of a crop that was sown a generation or more ago. However, there are still communicable cases in most communities and they are infecting and reinfecting their associates, some of whom are in the older age groups.

When the present older persons leave the scene and take with them their tubercle bacilli, they will be replaced by a generation of persons who have become elderly but in whose bodies there will be far less tuberculosis than there is in the present old-age group. However, as long as we have even a small number of communicable cases of tuber-

[1] Myers, J. Arthur: Man's Greatest Victory Over Tuberculosis, Charles C. Thomas, Springfield, Ill., 1940.

[2] Lees, H. D.: Tuberculosis Among College Students, Journal-Lancet **63**:98 (April) 1943.

[3] Myers, J. Arthur: County Accreditation Plan for Tuberculosis Control, J.A.M.A. **121**:921 (March 20) 1943.

No Armistice!

The day is coming when the great word will go out . . . "*cease firing*". Then thousands upon thousands of lives will be saved. Men who had given themselves to death will turn their minds to the hour of homecoming.

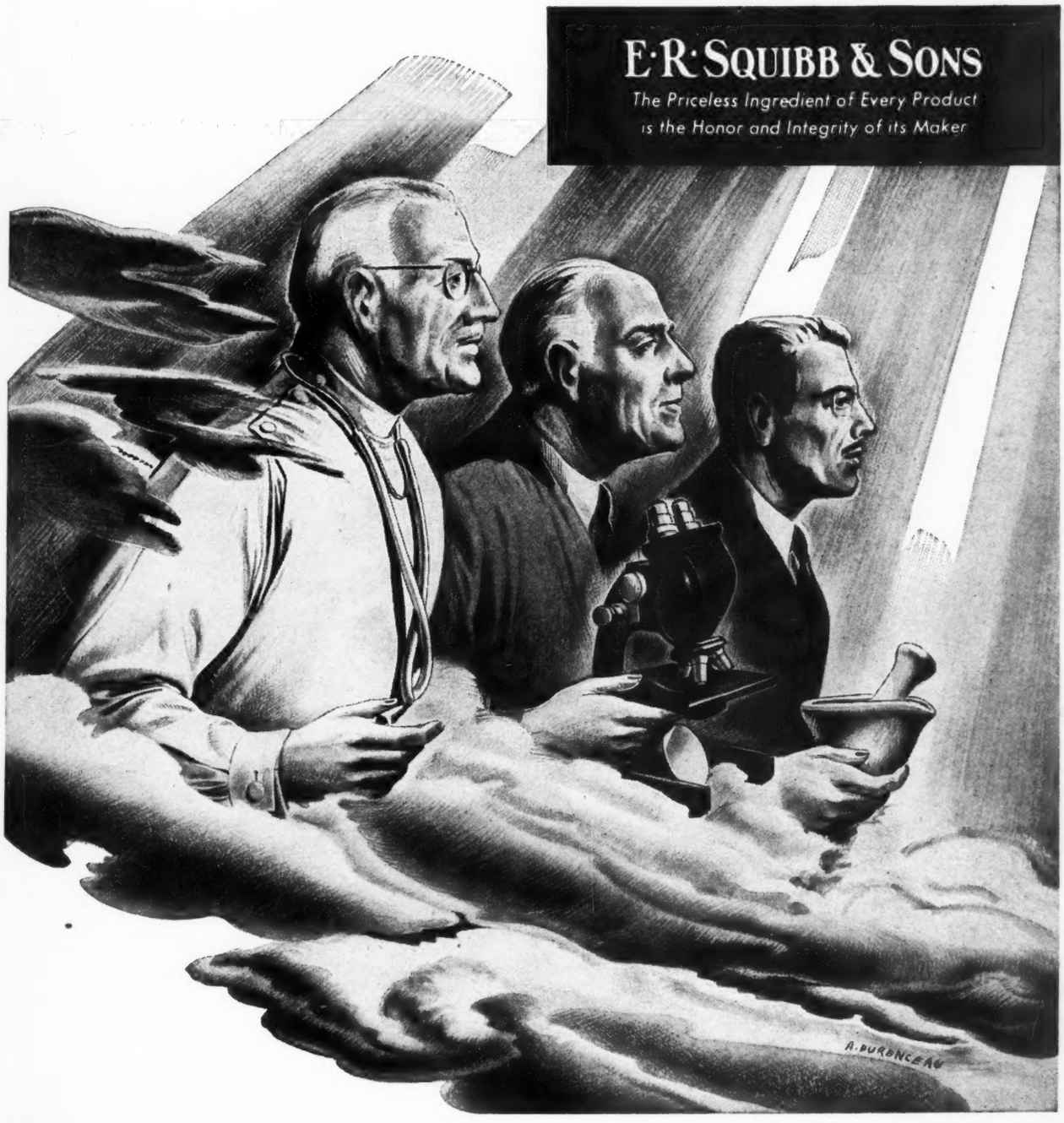
There will be men of medicine among them . . . physicians, surgeons, pharmacists . . . who will need no longer to stay the flow of blood, arrest infection, fan the spark of life back to full flame. They, too, will make ready to come back.

But by the nature of the professions to which they belong, these men cannot countenance an armistice in the fight to which they have given their lives. They must go on fighting while they live . . . fighting against disease and death, fighting for health and happiness and long, full years of life.

So, through the centuries the Medical and Pharmaceutical professions have declared "no armistice" against disease. So, in voluntary association with them for more than eighty-five years, the House of Squibb has fought on for humanity.

So, it will fight on, as they will, with no pause in the battle, no quarter to the enemy . . . and with unconditional dedication to the principle that has always inspired them and Squibb:

The right to serve is man's one freedom that must never be denied. For out of free men's devotion to their self-appointed tasks have come the great gifts to all mankind.



culosis uncontrolled, there will be a higher incidence of infection and, consequently, more clinical tuberculosis among older persons than among children and young adults because the older individuals will have had more years in which to come in contact with the few communicable cases.

There are more actual cases of tuberculosis among elderly persons today than there were a few decades ago because more people now attain old age. In 1850 the life expectancy at birth was 40 years in the United States. During the last half of the nineteenth century it increased to 47 years and in 1940 it was 63 years. When this century began, only 17 per cent of the total population of the United States was 45 years or older, but in 1940, 26.5 per cent was in this age period. Indeed, today there are approximately 9,000,000 persons in this country who are 65 years or older.

Tuberculosis Still Being Robbed

A few decades ago a number of diseases, such as diphtheria and typhoid fever, robbed tuberculosis of many of its future victims. Tuberculosis is still being robbed by such conditions as cancer and coronary disease. If the average length of life were 150 years, so that tuberculosis would have more time to mature, probably the majority of those infected with tubercle bacilli would develop clinical disease.

How Elderly Persons Contract Tuberculosis. Doubtless, many elderly persons acquired their infections in infancy, childhood and young adult life, but clinical disease did not manifest itself until old age was reached. When one examines periodically the chests of large numbers of elderly persons who react to tuberculin, it is not unusual to see clinical lesions make their appearance among those whose chests have previously been clear on x-ray film inspection.

Other persons have had clinical disease in earlier life which has been brought under control by Nature, aided or unaided by physicians and nurses, but which reactivates in later decades of life. I have recently seen a woman who in 1902 had pulmonary tuberculosis in the upper lobe of the right lung, with tubercle bacilli in the sputum. After a period of successful treatment she was apparently well and worked continuously as a teacher until 1935, when she had a pulmonary hemorrhage. Examination revealed reactivation of the old lesions and tubercle bacilli were again abundantly present in the sputum.

Now many persons become infected for the first time after attaining old age. They develop the first infection type, following which they are potential cases of the reinfection type of tuberculosis, just as they would have been decades before if their infections had occurred in early life.

Past and Present Diagnostic Procedures. There is still a large number of aged persons with significant pulmonary tuberculosis which is not detected during life. This is due, in part, to the following:

1. Often the symptoms are so mild that medical examination is not considered necessary; others with coughs, expectoration and loss of weight attribute the symptoms to such conditions as bronchitis and emphysema, which they think might naturally be expected to occur in old age and they are not examined.

2. All too often when elderly persons present themselves, the examination is done in a somewhat cursory way, and many physicians do not even look for tuberculosis because their early teachings led them to believe that this is a disease of young people and rarely or never occurs in the aged. In reality, for the number of persons living to the age of 45 or older, there is more clinical pulmonary tuberculosis among them than in any other age group.

Tuberculosis in elderly males has outdistanced that of elderly females. Indeed, Chadwick and Pope have recently said: "Tuberculosis is increasingly becoming a disease of older occupied men."[4]

No single symptom or group of symptoms is pathognomonic of tuberculosis in the aged. The disease cannot be diagnosed by physical signs or x-ray film inspection alone. The tuberculin reaction is specific for the presence of the first infection type of tuberculosis; therefore, it should be administered to all elderly persons and every individual who reacts should immediately have x-ray film inspection of the chest.

[4]Chadwick, Henry D., and Pope, Alton S.: The Modern Attack on Tuberculosis, The Commonwealth Fund, New York, 1942.

If no abnormal shadows are seen, these inspections should be repeated annually, as long as the lungs remain clear. If abnormal shadows are seen at any time, they are not diagnostic, since they may be cast by malignant disease, tuberculosis or pneumonia. To determine the etiology of the disease which causes the shadows is the work of the clinician and laboratory technician. Studies of sputum are of great importance. Not infrequently the assistance of a bronchoscopist is necessary to differentiate among tuberculosis, cancer and other diseases. *The tuberculin reaction and the recovery of tubercle bacilli are the only specific findings for tuberculosis. In the absence of one or both of them, regardless of symptoms and physical signs, including x-ray findings, a diagnosis of tuberculosis is never justified.* No elderly person should be labeled tuberculous until definite evidence has been obtained.

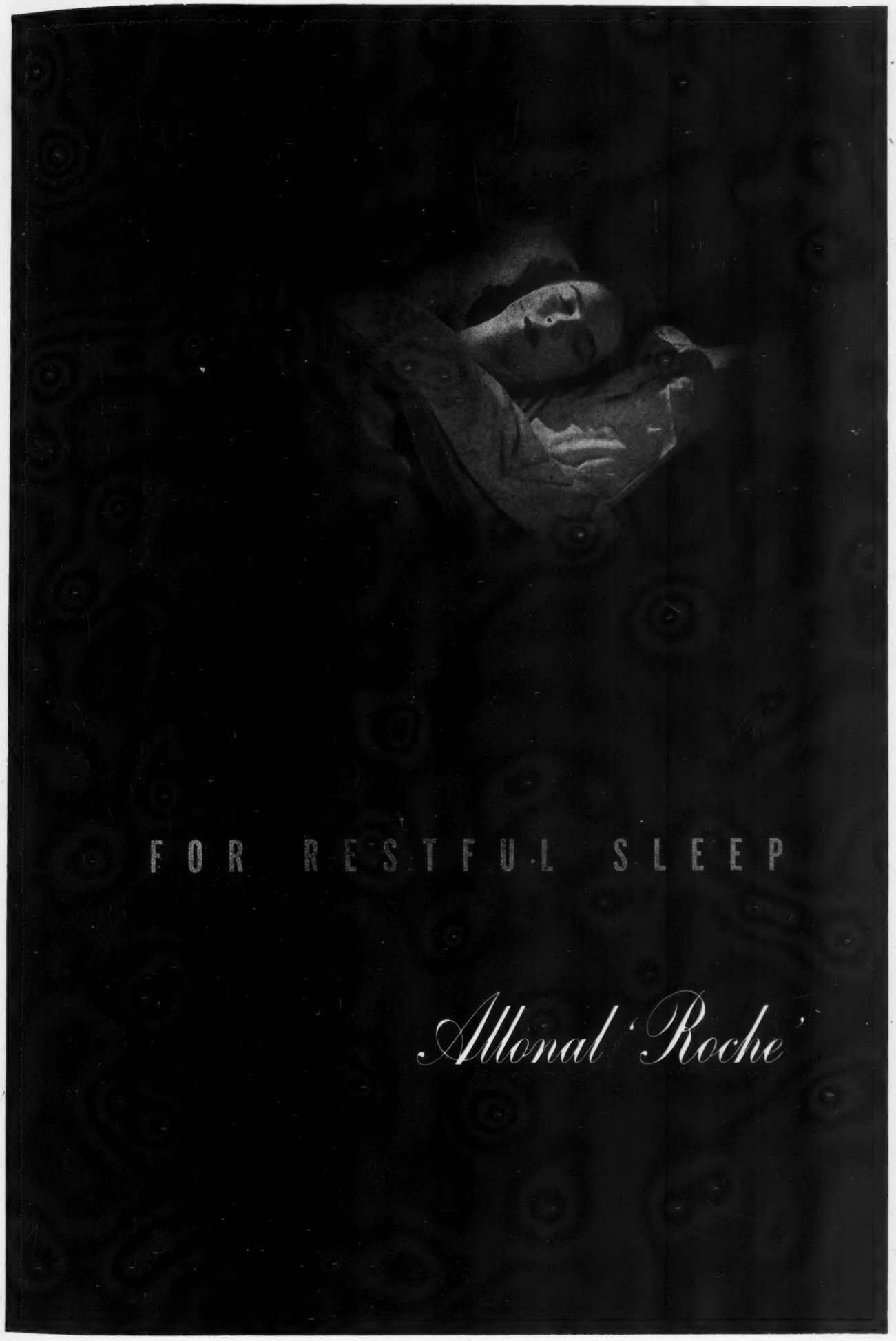
Treatment. Many elderly persons have pulmonary tuberculous lesions that have long since been brought under control by Nature. These persons should not be sent to sanatoriums or hospitals but should be examined periodically for evidence of reactivation. All too often the finding of an x-ray shadow, with no other evidence of active tuberculosis whatever, has been considered an indication for hospitalization.

Some Will Remain Ambulatory

Those persons whose lesions are active and communicable should have treatment instituted at once. For some, artificial pneumothorax controls the disease promptly and a few may even remain ambulatory.

A woman of 60 years was first examined in October 1935, after having had symptoms since January of the same year. Her body weight had fallen from 170 to 144 pounds. Her pulse rate was accelerated and the temperature moderately elevated; she had cough and expectoration, with occasional blood-streaked sputum. There was evidence of extensive disease, with cavity formation in the lower lobe of the left lung. By June 1936 her weight had fallen to 121 pounds. She refused hospitalization or bed rest at home.

Ambulatory artificial pneumothorax was instituted in August 1936, after which all symptoms disappeared. Her body weight soon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returned to 167 pounds and she has since led a normal active life.

For those whose active and communicable disease cannot readily be brought under control, the hospital or the sanatorium should be recommended at once. Here all general and special forms of treatment should be administered, as indicated. Extensive chest surgery may be done even in the fifth and sixth decades if the patient's condition warrants this procedure.

Many elderly persons have extensive disease in both lungs so that the disease cannot be rendered noncommunicable. In this case, they should be kept in isolation for the remainder of their lives. Some of them are apparently well and have working capacities consistent with their age; for them, special colonies should be established where they are much happier than in a hospital or sanatorium and, yet, are prevented from spreading their disease.

Prognosis. Many persons with chronic pulmonary tuberculosis, even with tubercle bacilli in the sputum, apparently live as long as they would have in the absence of this disease. They may die in the eighth, ninth and tenth decades from nontuberculous conditions. In others, disease that has been chronic for a long time may undergo exacerbations and result fatally in a short time.

The disease may extend to the bronchi and result in stenosis with atelectasis. A bronchus may be perforated,[5] following which extensive tuberculous pneumonia develops. The focus may rupture into a blood vessel or a large lymphatic duct and cause generalized miliary tuberculosis. A previously unsuspected focus in or adjacent to the central nervous system may rupture into a ventricle or the subarachnoid space and cause fatal tuberculous meningitis.

Danger to Others. The danger to others of communicable tuberculosis among elderly persons is great.[6] Many of them are grandparents and it is not unusual to trace fatal tuberculosis in children and others to them. Casparis cited the case of several young Negro maids who had successively died while working in one home, or soon after. Investigation revealed the fact that an elderly white man in this home had communicable tuberculosis which was previously unsuspected.[7]

Prevention. The only way at present to prevent clinical tuberculosis from developing among the aged is to protect individuals from tuberculous infection throughout life. Once primary tuberculosis develops in a human body it is beyond the control of the individual or his physician. It is true that in some persons all bacilli in the primary lesions may die but, unfortunately, it is also true that in others the bacilli survive and hold a constant threat over their health.

To date, we have no drug that has been proved capable of destroying tubercle bacilli in the human body. However, some of the sulfones, particularly promin and diasone, have been used with great success in experimental tuberculosis.[8, 9] Statements concerning their effects on tubercle bacilli in the human body must await further study.

Primary tuberculosis does not afford dependable immunity against clinical disease and, thus, there is no satisfactory premise on which to develop an artificial immunizing agent.

All that can be done for elderly persons who react to tuberculin is: (1) to examine them at frequent intervals so that clinical pulmonary lesions may be detected when they develop and so that they may be treated before causing illness or becoming communicable; (2) to protect all nonreactors, as well as reactors, against exposure to communicable cases of tuberculosis, since elderly persons may be infected or reinfected to their detriment. It is as important to protect them against tubercle baccili as it is to protect persons in other decades of life.

[5]Arnstein, A.: Non-Industrial Pneumoconiosis and Pneumoconiotuberculosis and Tuberculosis of the Mediastinal and Bronchial Lymph Glands in Old People, Tubercle **22:**281 (Dec.) 1941.

[6]Peters, L. S.: Tuberculosis of the Aged, The Cure of the Aged (Geriatrics) 172-190, by Malford W. Thewlis, C. V. Mosby Co., St. Louis, 1942.

[7]Casparis, H. R.: Personal Communication.

[8]Feldman, W. H.: Hinshaw, H. C., and Moses, H. E.: Promin in Experimental Tuberculosis, Am. Rev. Tuberc. **45:**303-333 (March) 1942.

[9]Petter, Charles K., and Prenzlau, Werner S.: Treatment of Tuberculosis With Diasone, Am. Rev. Tuberc. In press.

Is This Professional Pharmacy?

THE pharmacist, busily weighing powders, is interrupted. "Have you any cokes?" "No, I'm afraid not, cleo colas and ginger ales only. Open the box and help yourself." After the visitor drinks her Cleo: "Shall I pay you?" The pharmacist looks up to see if the girl who generally serves the drinks has come back from lunch. She hasn't. "Yes, please. Just a moment. Thank you."

The pharmacist then washes his hands and rushes back to try to get capsules filled. He has filled half of them when several other customers arrive. "Any Baby Ruths?" "Yes." "Now what have you that is cold and wet? Just anything. We can't be choosy these days."

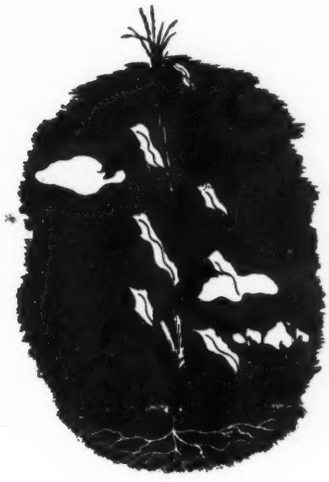
That attended to, the *unimportant* business of filling the capsules is continued.

Perhaps some of you will think this is overdrawn and I hope you do for it will mean that it is not happening in your hospital. Certainly, this is not professional pharmacy.

After the operating room the pharmacy is the most important department in saving life and restoring health and it should reflect professionalism. Cleanliness is as essential in the pharmacy as in the operating room. Soft drinks cases bring in roaches and other insects and we know of no way of sterilizing these bugs. Bottles are broken; cooky packages and chewing gum wrappers make the pharmacy unsightly.

We recognize the need for these refreshments, also for magazines, but the pharmacy is not the place for them. Cannot these commodities be kept in a separate shop? This could be under the direction of the women's auxiliary or the dietitian if it is primarily a coffee shop. To handle them as a sideline in the pharmacy is both professionally and economically unsound.

Time spent in dispensing these items can be used by the pharmacist in manufacturing pharmaceuticals and in administrative and educational duties. Hospital standards are lowered when the standards of one of its most important departments are lowered.



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NOTES AND ABSTRACTS

Conducted by the Staff of the Pharmacology Department Wayne University, Detroit

Drug Accidents

All too frequently serious results follow in the wake of promiscuous or improper administration of drugs. Many otherwise excellent remedial agents are unjustifiably indicted because of inadvertent errors associated with such administration. The list of these drug accidents is large and hence in this brief presentation only a few of such incidents will be discussed.

Magnesium Sulphate.—Recently, Fawcett and Gens of Boston (J.A.M.A. **123:**1028 [Dec. 18] 1943) reported two cases of poisoning by magnesium sulphate. The symptoms of the first patient were not recognized as being associated with the profound depression resulting from magnesium overdosage. Comparable symptoms in the second patient led to the indictment of the epsom salts as the responsible agent and properly heroic antagonistic treatment of the depression by calcium gluconate intravenously completely restored the patient within a few hours.

This case illustrates the fact that the rectal mucosa of some patients is more readily permeable to magnesium than is the same mucosa of other patients. This patient had impaired renal function prior to the administration of morphine and, since normal kidney function is mandatory whenever magnesium salts are administered, another type of evacuant would no doubt have been more appropriate in this instance.

It is believed that some magnesium is always absorbed from the gastrointestinal mucosa but that its depressing effect upon the central nervous system is obviated by its rapid excretion by the kidneys. On the other hand, if such an evacuant as sodium sulphate of the so-called saline cathartic group or, better still, if isotonic solution of sodium chloride is employed the excess sodium ion inflicts no depressing effects comparable to that of magnesium. Thus, renal impairment labels any patient as a poor subject for an epsom salt enema.

Boric Acid.—Another drug that is ordinarily considered by the layman and, unfortunately, also by many physicians to be rather innocuous is boric acid. It has a wide range of toxicity; it has caused death after 15 grams in some cases whereas 28 grams have been recovered (Peyton and Green, South. Med. J. **34:**1286, 1941) after 700 cc. of a 4 per cent solution had been accidentally given instead of an isotonic solution of sodium chloride by clysis.

A traditional use of saturated solutions of boric acid (4 to 5 per cent) involves the genito-urinary surgeon. For decades it has been customary to instill into a urinary bladder, suspected of having been ruptured, from 300 to 500 cc. of this solution. Failure to regain the instilled volume denotes loss through the perforation into the peritoneal cavity.

The peritoneum readily absorbs many substances and boric acid is one of them. This absorption may be so rapid that serious poisoning and death may result. The latter is not at all uncommon (Ross and Conway, Amer. Journ. Surg. **60:**386, 1943), a death having followed such usage recently in this district.

Is it necessary to instill boric acid in this situation? One can emphatically state that it is not. Boric acid is a poor antiseptic and other safer antiseptic agents for this procedure are available if an antibacterial agent is necessary.

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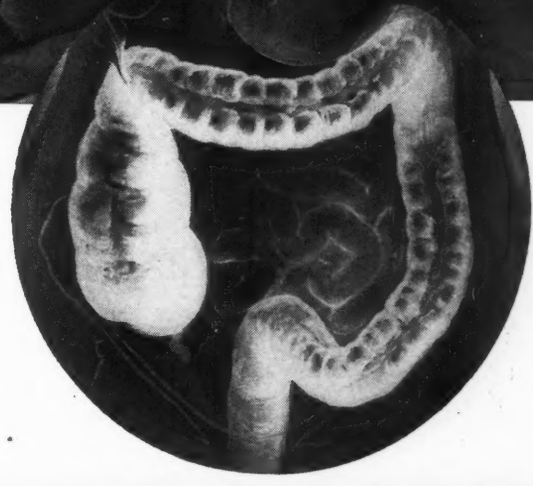

OF PRIME IMPORTANCE to the well-being of the hospitalized patient is restoration and maintenance of "habit time."

Petrogalar gently, persistently, safely helps to establish "habit time" for bowel movement. It is evenly disseminated throughout the bowel, effectively penetrating and softening hard, dry feces, resulting in comfortable elimination with no straining . . . no discomfort.

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Petrogalar is an aqueous suspension of pure mineral oil each 100 cc. of which contains 65 cc. pure mineral oil suspended in an aqueous jelly. Constant uniformity assures palatability—normal fecal consistency. Five types of Petrogalar provide convenient variability for individual needs. Available in cases of 10¾ oz. hospital units for individual patients.

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FOR SAFE RETURN TO "HABIT TIME"

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A dilute solution (.05 per cent) of sulfathiazole, or zephiran, in a concentration of 1 to 10,000 or 1 to 15,000 is generally innocuous to the unsensitized host and is a rather efficient antiseptic in these concentrations.

Doryl and Mecholyl.—Excellent agents for initiation of smooth muscle contraction in both the urinary bladder and intestine are presented in the forms of mecholyl (acetyl-betamethyl choline) and doryl (carbaminoylcholine). These are choline derivatives and act indirectly upon the bladder and intestine by way of the parasympathetic nerve supply of these organs.

Unfortunately these agents act elsewhere upon structures innervated by parasympathetic nerves, especially the heart and bronchioles. These drugs, in overdosage, powerfully stimulate the vagus nerve to slow the heart and to constrict the bronchi and the only effective antagonist of these effects is atropine in 1 to 2 mgm. dosage intravenously. Since the effective dose of doryl (carbaminoylcholine) is 0.2 to 0.4 mgm. for bladder evacuation one must treat the drug with utmost respect and be most certain of the dosage ordered; failing this, immediate death may ensue.

Doryl was formerly obtainable in two ampule forms, one already prepared for parenteral administration and the other containing crystals to be dissolved for external use in the eye. With these two forms available, confusion in dosage was inevitable with the more potent ophthalmic preparation in case the latter was inadvertently employed when the parenteral had been intended.

These experiences should not discourage the use of these excellent cholinergic drugs but should militate against the practice of prescribing any medication by "ampule." Dosage of a drug in terms of milligrams should invariably be stipulated regardless of the nature of the drug.

Morphine, salicylates and sulfa derivatives are but a few illustrations of drugs that are not usually prescribed by ampule. Why should such potent agents as doryl and mecholyl be permitted to fall into such dangerous byways?

Further assistance in obviating drug accidents should be forthcoming by better differentiation of various forms or preparations of the same drug, by proper instruction of nurses and pharmacists regarding potent pharmacologic action of certain drugs and the antagonism or correction of these potent actions, and also by postgraduate instruction of the physician not only regarding fundamental pharmacologic and undesirable actions of newly introduced drugs but also regarding new facts pertaining to old medications that have stood the test of time.

The physician, nurse, pharmacist and pharmaceutic manufacturer must share equally the responsibilities associated with proper and judicious medication of the patient.—Fredrick F. Yonkman, M.D.

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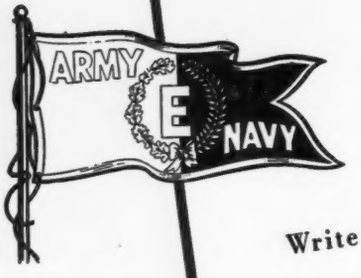

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CLINICAL BRIEFS

Conducted by E. M. Bluestone, M.D.

Talcum Powder Hazards

Although the use of talcum as a dusting powder for rubber gloves presents serious hazards, these hazards have scarcely been recognized by most surgeons who blithely continue to use it. Postoperative complications resulting from its use include intestinal obstruction resulting from foreign body peritonitis, intraperitoneal adhesions and granulomas.

Another hazard of importance is the accidental entrance of talcum powder into the conjunctival sac of operating room nursing personnel. Parenthetically, it may be mentioned that, on the basis of a study of the talcum hazard

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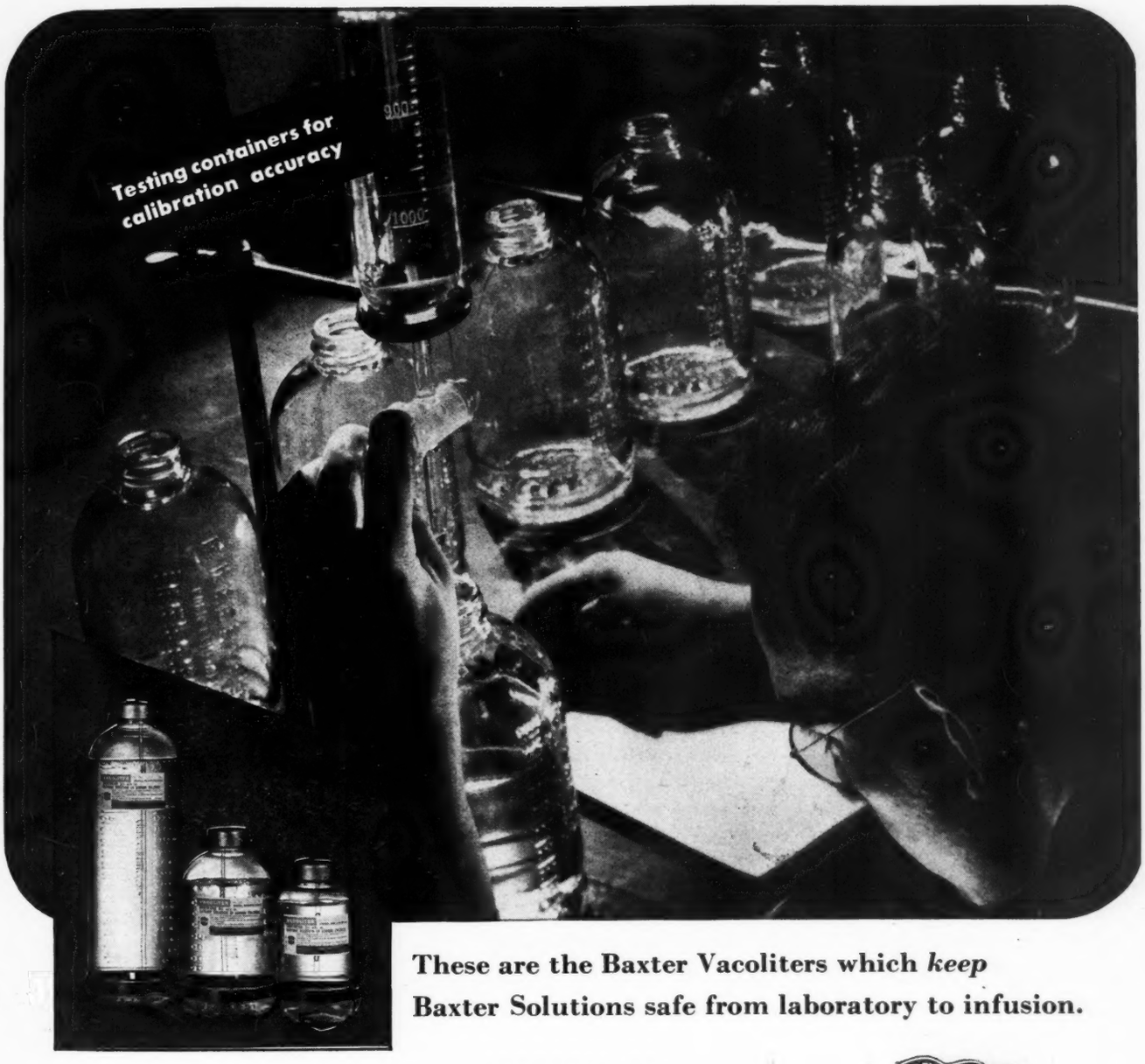

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in the preparation of rubber gloves for sterilization made by the Illinois Division of Industrial Hygiene, it has been recommended that measures to control and remove talc dust be instituted in order to avoid health risk to nurses.

Seelig, Verda and Kidd, in an article, "The Talcum Powder Problem in Surgery and Its Solution," in the *Journal of the American Medical Association* for Dec. 11, 1943, show experimentally the permanent and progressive type of inflammatory response to the intra-abdominal introduction of talc, and they suggest potassium bitartrate as a substitute. This substance meets the physical requirements imposed by steam sterilization; it is readily disposed of by the body tissues and fluids; it causes no peritoneal adhesions, and it produces no undesirable skin reactions. —SIGMUND L. FRIEDMAN, M.D.

Transfusion Experience

A thorough study of a year's experience with the "transfusion unit," or blood bank, of Jefferson Hospital, Philadelphia, is described by L. A. Earf, M.D., and H. W. Jones, M.D., in the *Annals of Internal Medicine* for July 1943. During this period (July 1941 to July 1942), 3906 donors were obtained and 2869 blood infusions and 695 plasma infusions were given, with a reaction incidence of 3.2 per cent for the blood and 0.14 per cent for the plasma.

This reaction incidence is somewhat less than that experienced in most hospitals and the authors recommend the following precautions:

1. In typing blood use high titer typing serums and the centrifuge, the Landsteiner technic.
2. In cross-matching use a centrifuge but if only the slide technic can be used wait at least thirty minutes for possible delayed agglutination.
3. Use only fasting donors who are free of such infections as infected teeth, tonsils and sinuses and diseases, such as influenza and malaria.
4. Keep all apparatus meticulously clean; solutions should be freshly prepared, using only pyrogen-free distilled water.
5. Use cellulose tubing now available on the market which is discarded after one use (the authors claim that the usual rubber tubing harbors pyrogenic substances).
6. Use blood no older than four days; many of the qualities of blood change after that period of storage; blood should be stored at 35°C. and administered cold and very slowly.
7. Since amount of blood to be given varies, compute the dosage.

The authors recommend the use of dried plasma, stating that the important constituent of prothrombin decomposes rapidly in standing fluid plasma. Plasma was obtained by separating or centrifuging all blood unused after four days, pooled and dried by a Hill-Adbevae machine. One pint of blood will yield from 12 to 16 G. of dried plasma, which can subsequently be injected by dissolving again in 40 cc. of sterile distilled water. This is an extremely efficient method since the plasma can be dissolved and injected in from three to five minutes.

The authors recommend for consideration the processing of cadaver blood for plasma, with which Russia has had much success. — ALEXANDER W. KRUGER, M.D.

Grafting Without Sutures

A method of skin grafting requiring no suturing has recently been described by Dr. E. M. Sano in the November 1943 issue of *Surgery, Gynecology and Obstetrics,* in an article entitled "A Coagulum Contact Method of Skin Grafts, as Applied to Human Grafts."

Doctor Sano uses two cement or binding substances derived from normal blood. One binding substance is painted on the graft, the other upon the area to be grafted, and the two surfaces are apposed. Adhesion occurs al-

FREE BOOKLET
on Blood Plasma Equipment

An illustrated booklet covering the apparatus and equipment for various blood plasma procedures is now available. This booklet not only lists the basic apparatus but contains diagrams of donor, pooling and administration assemblies as well as full specifications on the apparatus. A convenient bibliography is included for those who wish to review the literature on the preparation of blood plasma. The equipping or remodeling of a blood bank and plasma processing laboratory is in reality a problem of plant engineering and requires a fairly wide range of apparatus and equipment. To better serve the laboratories installing a blood bank our technical staff has made a thorough study of the various processes now in use. These men will be glad to work with you in planning the new blood bank, in installing the equipment and in training your personnel.

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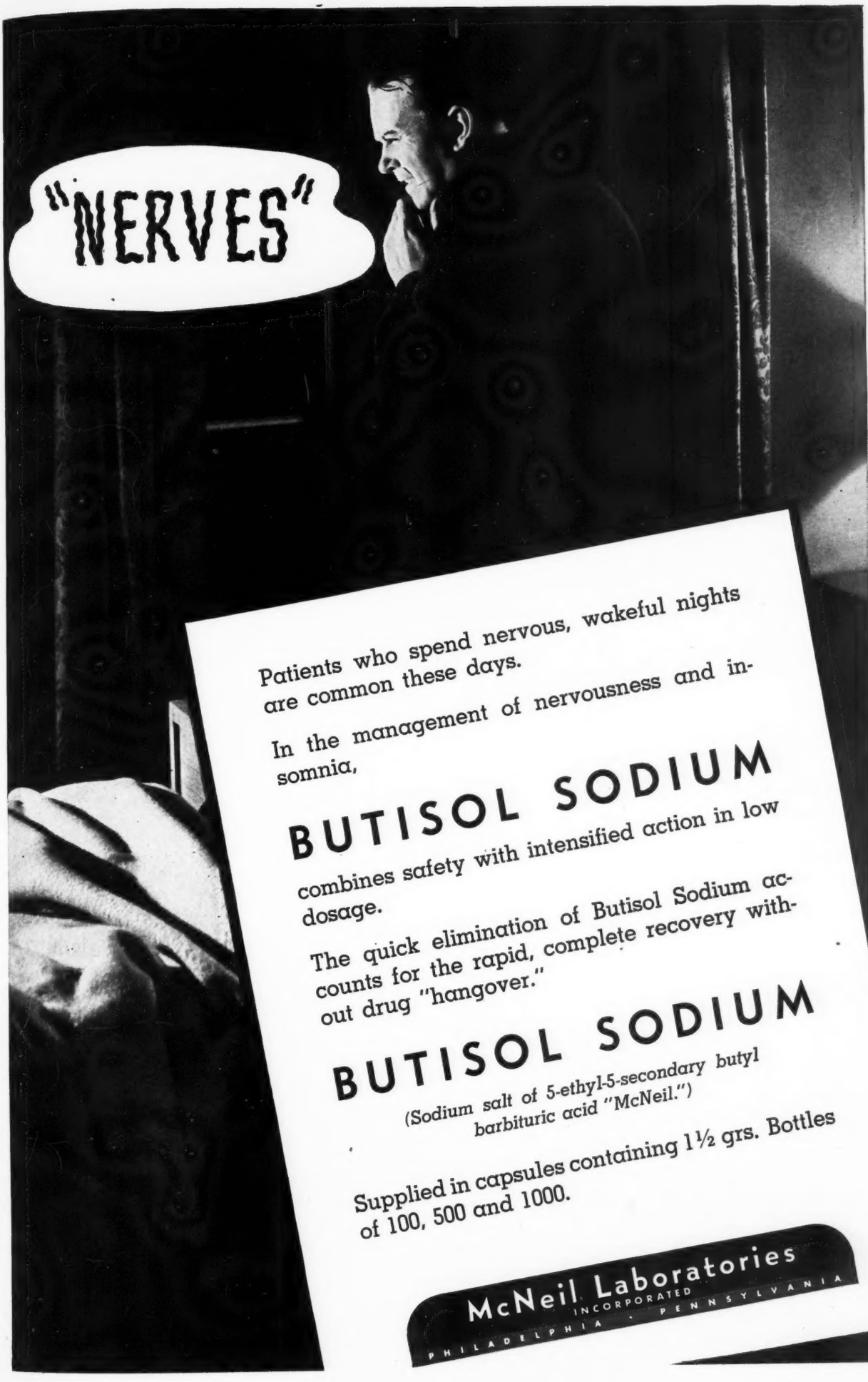

Patients who spend nervous, wakeful nights are common these days.

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most immediately. Oozing of blood ceases.

The graft is penetrated by blood vessels so rapidly that it acquires a reddish purple color and may even bleed within forty eight hours. Sulfonamides may be combined in the process to control infection. Some of the results have been impressive, and in one recent case the patient was walking upon a graft on the heel within a week.

The advantages of this method seem to be several: there are no stitches and therefore no stitch scars; serum does not accumulate beneath the graft, and therefore grafts are not lost because of floating; the speed with which fixation of the graft occurs saves much besides hospital expense.—SIGMUND L. FRIEDMAN, M.D.

"Therapeutic Fads"

Dr. O. H. Perry Pepper has written an excellent review, "The Fever Curve of Therapeutic Fads," in the December 1943 issue of the *American Journal of Medical Sciences* of some of the therapeutic fads of the past, in order to teach us the symptomatology by which we may recognize the danger and avoid the contagion.

Venesection is perhaps the most familiar example; the indications for its use were logical enough to Benjamin Rush, after whom its use ended in the greatest possible abuse. Surgery for nephropexy and gastropexy seemed to find justification in the easily demonstrated ptotic position of the respective organs, and such surgery appears to us now to have been unjustifiable. Then came intestinal autointoxication with the resultant absurdity of innumerable "high colonics," followed by almost universal tonsillectomies.

Pepper warns that these therapeutic fads of the past can be repeated in the present and the future. To avoid them we must be critical and even skeptical. We must not, however, lose our open-mindedness in the evaluation of new therapy.—SIGMUND L. FRIEDMAN, M.D.

Caudal Anesthesia

A study of the use of continuous caudal anesthesia in 200 consecutive cases undertaken pursuant to the widely discussed article on this subject by Edwards and Hingson, published in 1942, has been reported by Lyons and Hansen in the *American Journal of Obstetrics and Gynecology,* January 1944.

Only five cases were unsatisfactory in the entire series—195, or 97.5 per cent, being quite successful. This method was equally effective in primipara and multipara patients and in those delivering spontaneously and those requiring operative intervention.

Contra-indications are few: (1) abnormalities in the sacrum (which are rare); (2) infections in adjacent skin or tissues; (3) hypersensitivity to local anesthetics (also relatively rare).

The technic, though relatively simple, requires much experience and is not to be confused with the technic in usual short caudal anesthesias. Anesthesia is begun when the patient is in labor, first giving amytal or nembutal by mouth about fifteen minutes before beginning injection of anesthetic. The local anesthetic used was metycaine injected as 1.4 per cent solution at intervals during a period of time which averaged 4½ hours for primiparas and 2¾ hours for multiparas, the quantity varying from 110 cc. for primiparas and 65 cc. for multiparas. Special malleable stainless steel needles were used (for no more than three times).

Complications were infrequent and never serious and, except for transitory nausea, headache and dizziness, were nearly always due to defective technic or equipment.

In conclusion, the authors state that "no obstetric complications which could be considered as contra-indicating the use of this procedure were encountered by us."—ALEXANDER W. KRUGER, M.D.

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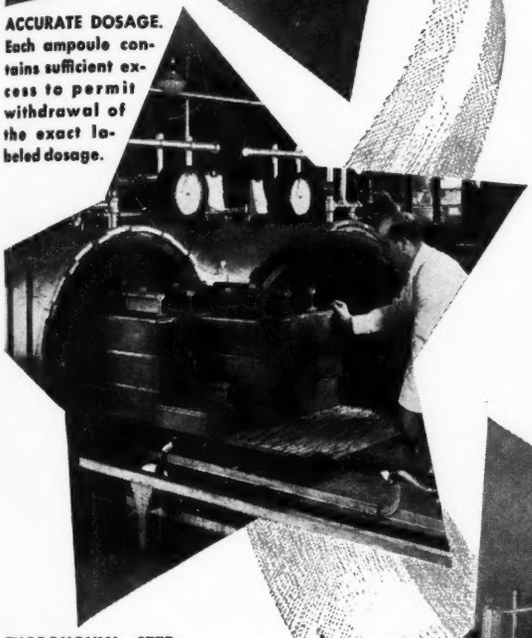

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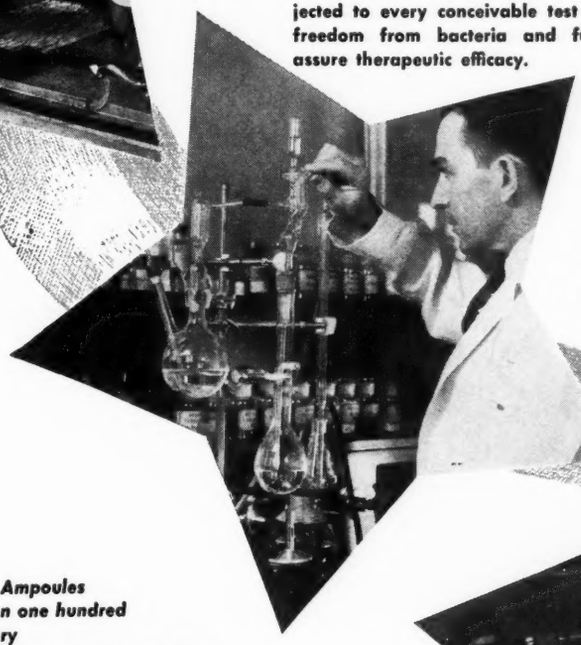

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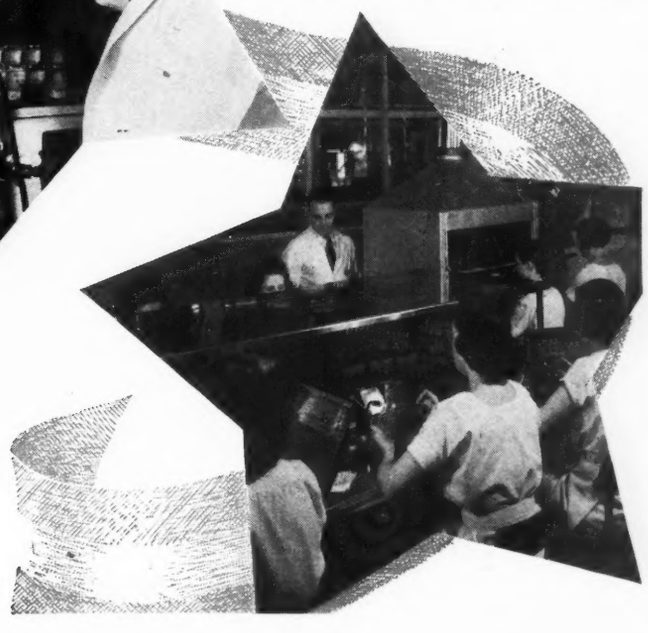

• Parke-Davis Glaseptic Ampoules are available in more than one hundred combinations to meet every need of the physician for parenteral medication. A special booklet listing and describing this comprehensive line of products will be sent on request.

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Present PAINT Problems

PAINT—quality paint, that is—while still available is becoming scarce. Reputable manufacturers are frank to acknowledge this fact and would have their institutional customers know the truth so that they can plan accordingly.

Here's the Truth

Those types of paint that heretofore have boasted a high oil content will be definitely inferior in months to come to those originally offered, and apparently there is little that can be done about it unless some relief comes from bumper flax crops in the United States and Canada. There is also the possibility of a better than normal Argentine flax crop, some of which we may obtain, depending upon our relations with that country. Various ingredients that have contributed so largely to quality are high on the list of war essentials and must do other duties for the duration.

Paints with high oil content, which include gloss wall finishes, semigloss wall finishes, exterior house paints, high gloss exterior and interior enamels, semigloss and eggshell enamels, are the ones most seriously affected. This is because linseed oils and all other vegetable oils are on an allocation basis, which means that the manufacturers can count on only 50 per cent of the amounts used as an average during 1940 and 1941.

Linseed oil, among other war uses, has been found to constitute an edible food. Thousands of pounds of margarine made from this product are going through lend-lease to Russia, China and other countries. This serves to show the quantities of oil that are being diverted from the paint industry. No alternates are available because they, too, are even more critical than linseed oil.

Essential oils are not the only problem, however. Original formula enamels of top quality have an alkyd resin, one constituent of which is phthalic anhydride. This is no longer available to the paint industry. Instead, it goes into the manufacture of clear plastics used for the bombardier cages and gunner turrets on modern aircraft. In consequence, when original stocks of the formula material are depleted, enamel will not be of as good a quality as formerly.

Another side of the picture is not quite so discouraging. This has to do with those varieties of paint that do not have high oil content: flat wall paints, for example. Unless something unforeseen prevents, the administrator may continue to count on these provided he is not too particular about the precise shade. No longer is it possible to decide on a certain color with any definite assurance that it can be reproduced. To avoid disappointment and time in studying paint charts, therefore, it is safer to be prepared with two or three alternates. Pastel tints, which generally are preferred in hospitals, are not affected by government restrictions as much as are deep shades, such as chrome green.

Purchasers Can Help

There are numerous ways by which hospital purchasers can help the government in its paint conservation program. Painted surfaces that are properly maintained will not require refinishing as frequently as those that are not. It is better to wash a good paint when possible than to put paint of poor quality on top of a reputable product.

Special attention should be given, therefore, to washing methods, particularly the materials used. Beware of scouring cleansers or solutions that are dramatically efficient; they may contain caustics that will eat into the paint. A mild solution with plenty of elbow grease will prove more satisfactory in the end.

When preparing new paint or paint that has been stored for a period of time, the manufacturers' instructions should be read carefully, not once but twice. The solution that should be added depends on the base used by the manufacturer in making the paint. No one solution can be used for all paints and when instructions are not followed the paint may curdle and not dry properly.

Paint never should be applied at a temperature of less than 50° F. because it does not flow smoothly and sometimes runs and sags and does not adhere properly. Paint that is stored should be kept at a moderate temperature. Extremes either way are not conducive to the best results.

Hospital people may help the paint producers and in so doing help themselves in the handling of metal containers. Should the product be purchased in 5 gallon lots, the tins must be returned. Inasmuch as the life of these containers is comparatively short, they should not be bounced around or dented. Severe dents prevent the manufacturer from cleaning the container thoroughly before refilling and, after several rough experiences, the container becomes too weak for further use.

Equally important is it not to bounce cans off the trucks as this will result in denting the edges and thus prevent the lid from closing snugly, which in turn prevents proper storage of paint.

A Word About Brushes

Now for a word or two about brushes, which play so important a part in the painting process. Only a limited amount of hog bristle is available and all of it is going to the Army and Navy. This means that hospital officials are going to be confronted with a brush problem—all the more reason, therefore, for taking care of those brushes that are now available.

Brushes should be cleaned immediately after use with turpentine or with a mild brush cleaner. Strong preparations sometimes used for this

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U. S. Army Air Forces Photo

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purpose take the life out of the brushes and handicap the painters who use them. Soaking in linseed oil will preserve the brush. This is not always possible today owing to the scarcity of oil. If oil is not available the best bet is to clean brushes promptly after using, dry and wrap them in paper in order to keep them clean.

In the meantime producers are hard at work finding some solution to the paint brush problem. One interesting development is a synthetic bristle brush made of non-priority material.

As a final recommendation to those who are confronted with a paint problem it is suggested that the guidance of reputable manufacturers be solicited.

ENGINEERS' QUESTION BOX

Question 36: What is the best way of testing lamps, ballast coils and starting switches on our fluorescent lighting fixtures?—J.B., Me.

ANSWER: One should have the commonest troubles and failures that are likely to happen jotted down in some kind of a table form, such as that shown in the accompanying box.

One good way to test both the lamps and the starters at the same time, and for all different sizes of lamps, is to make up a test board.

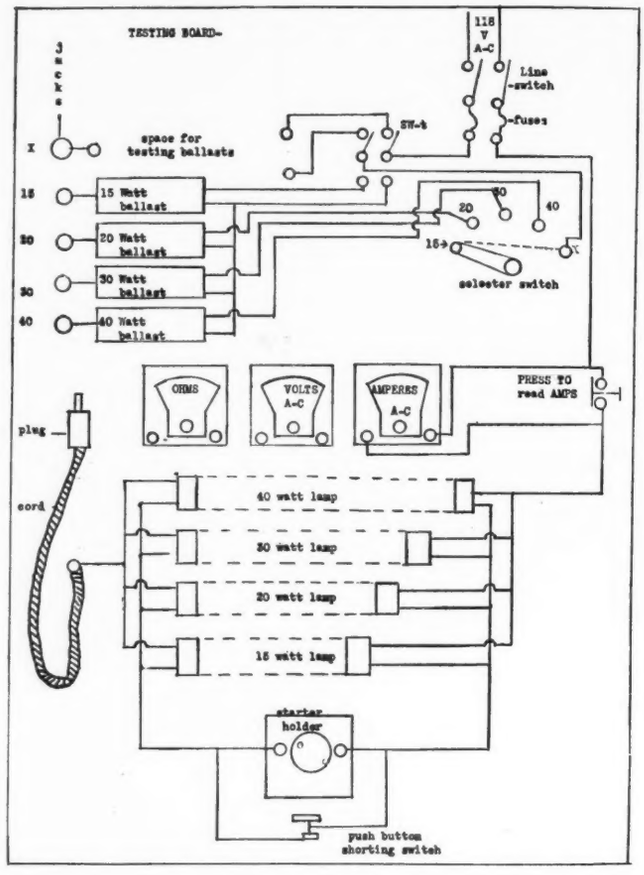
On the board are mounted lamp holders to take the different lengths of lamps. Below these the starter holder is mounted.

There should be at least two starter holders, one for a starter that is known to be good, and a switch arrangement to throw over to the starter to be tested. A ballast that is known to be good is also mounted out of the way at the top of the board. Instead of the two starter holders, and to cut down time, one could install a push switch across the one starter holder to short out the starter on test.

To test a lamp, place it in the proper lamp holders, close the line switch and, if the board is built with only one starter holder, press the shorting button for several seconds, then release. The lamp should light immediately if the lamp is making good connections in the holders and there is proper voltage on the line. The lamp should be rotated so that the pins make contact with opposite holder contacts and the test tried again.

To test a starter, a lamp that is known to be good should be inserted in the holders and the starter to be tested should be inserted in the starter holder. Close the line switch and the lamp should light up in a few seconds if the starter is good and the lamp will operate continually. If the ends of the lamp glow but the lamp will not start, the starter contacts are stuck and it should be removed and discarded. If the ends of the lamp do not glow at all, the starter breakdown voltage is too high and the starter should be discarded.

In these tests the line voltage should be about 118 volts and the test board should never be used on less than 110



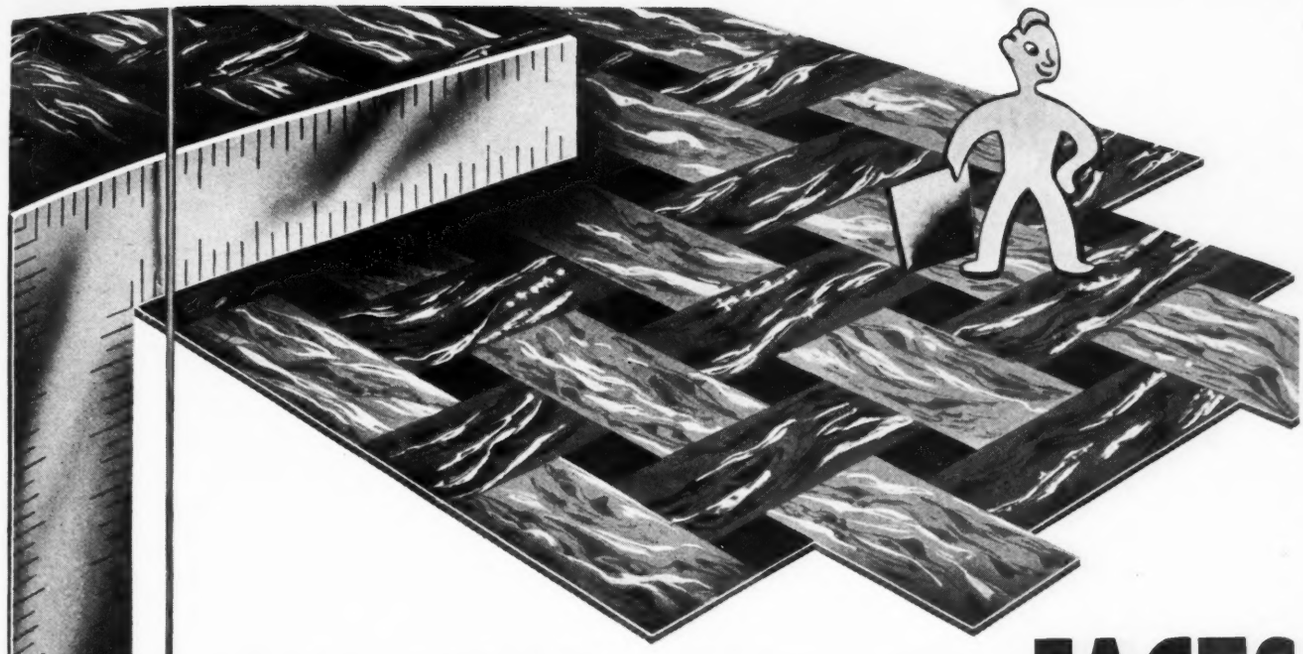
Trouble Check Chart for Fluorescent Equipment

INDICATION OF TROUBLE	REMEDY
1. Lamp won't start or lamp flashes on and off.[1] (Note: A flashing lamp usually indicates end of lamp life.)	1. Be sure lamp is properly seated in lamp holders. 2. Replace with tested lamp. 3. Replace starter with tested one. 4. Be certain of proper line voltage. 5. Check lamp holders, wiring and ballast.
2. Lamp flickers, arc wiggles, spirals or flutters.	1. Turn luminaire on and off several times. 2. Allow a new lamp to operate several hours for seasoning. 3. Remove lamp and shake with one end down. 4. Replace lamp if flicker persists. 5. If flicker is repeated in a new lamp, replace the starter.
3. Ends of lamp glow,[2] no starting effort.	1. Replace starter. 2. Be sure wiring connections agree with diagram on ballast.
4. Lamp starts slowly (should start in a few seconds).[1]	1. Be certain of proper line voltage. 2. Replace the starter.

[1]If these troubles are encountered where room temperature is below 50°F., the arc characteristics change and fluorescent lamps may not operate satisfactorily. A glass cover for the reflector to enclose the lamp will in most cases be sufficient.

[2]If luminaire is equipped with "No-blink" starters, continuous end glow indicates normal lamp failure.

Material is taken from an article by W. H. Kahler of the Westinghouse Electric and Manufacturing Company.



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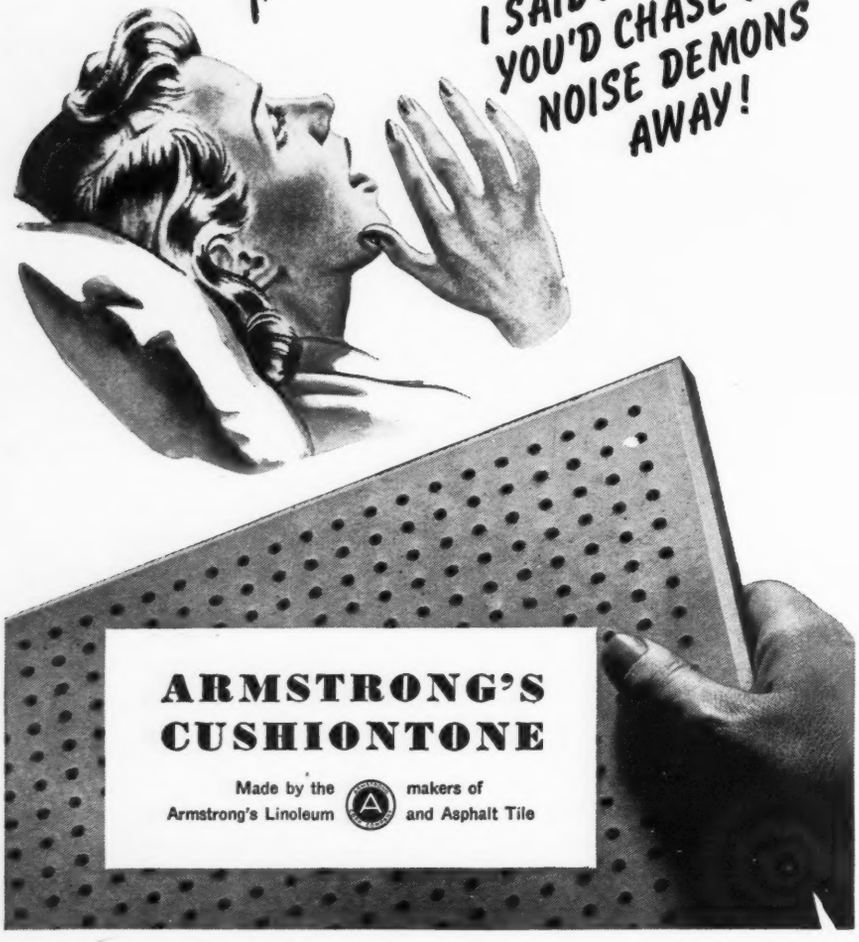

volts. It may be well to mention that there should be installed not one ballast but a proper ballast for each lamp to be tested.

On our test board shown in the accompanying sketch, there is installed a plug and jack arrangement together with the 4 point transfer switch. This could just as well be made up with plug and jack switching, too. The ammeter, voltmeter and ohmmeter will be found useful in the tests that can be made on this board.

If a 40 watt lamp is to be tested fit the lamp in the holders and make sure that the pins are well in place. Select the 40 W. jack and insert the plug on the left hand side of the board. Turn the rotary selector switch to 40 W. and close the line switch. A starter may not be in the starter holder, so press the push button and the lamp, if good, will light. The current taken by the ballast and the lamp, on starting and after starting, may be read by pressing the meter button on the right-hand side of the board.

The voltmeter may be used with leads to test any point throughout the circuit for voltage drops. When one gets to know the proper voltages that should appear at the different points, one may easily tell what the trouble is.

The ohmmeter is used to test different normally closed circuits and also to test for shorts in the equipment under test so as to prevent one from placing a defective unit across the circuit; thus it cuts down the danger of damage to equipment. Then, too, the user will get to know what the resistance of a certain piece of equipment should be, and if it is well above or below the average, the indications are well discernible.

To test a ballast on the test board, a space is provided with a plug jack and three binding post terminals to which the ballast leads are to be fastened. It will be noticed that all the tests are shown to be made on a certain kind of ballast, the three wire type, and all the tests are also of the single lamp circuits. It is left to the user to make any changes to suit his needs.

To test a ballast, place the plug on the left-hand side of the board into the upper jack and throw the switch marked SW-T to the upper position. With a good lamp, or one that has just been tested, the ballast may be tried for operation but, of course, the proper lamp for this ballast must be in the lamp holders. Always use the ohmmeter to test for shorts and grounds before placing ballasts on test.—JOSEPH C. FISCHER, *chief engineer, Milwaukee County Institutions and Departments, Milwaukee.*

(Mr. Fischer's discussion of normal lamp operation will appear in May.)

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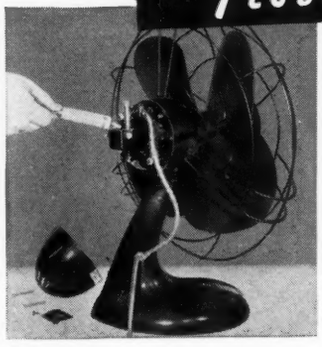
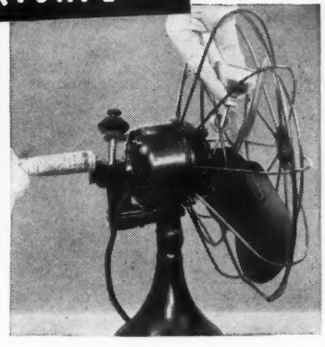
G. H. Koch, Chief Fan Engineer, Westinghouse Electric & Manufacturing Co., Springfield, Mass.

1 LUBRICATE

STREAMLINE TYPE

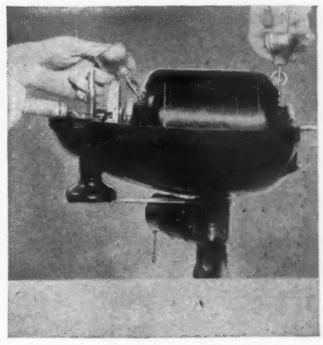
Oil or grease front bearing. Grease gears and rear bearing. (Follow manufacturer's instructions as to grade of oil and kind of grease.)





CONVENTIONAL TYPE

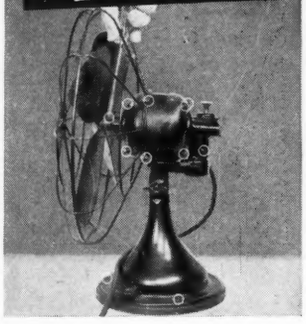
Grease oscillating gears and rear bearing. Oil or grease front bearing.



LARGE CIRCULATOR TYPE

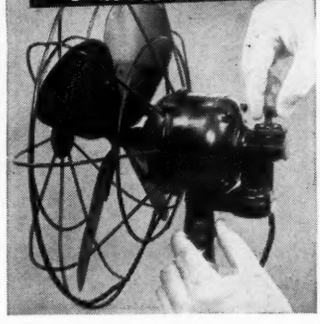
Oil motor at both ends. Grease the oscillating gear.

2 TIGHTEN



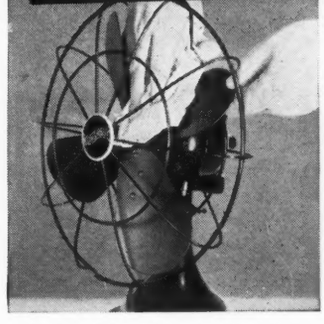
Tighten set screws in fan blade hub, also screws or nuts holding fan guard, motor case and other parts

3 TEST ADJUSTMENTS



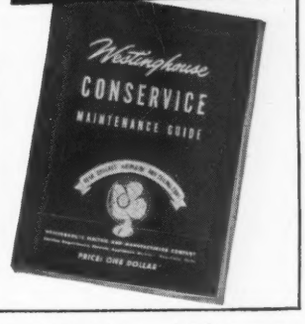
Always loosen clamping screws for directional adjustment. Never force by twisting guard.

4 CLEAN BLADES



Accumulated dirt and dust cause blade unbalance with resulting vibration and bearing wear.

5 GET THIS FREE BOOK



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HOUSEKEEPING

Let's Have Harmony

In his lecture on service departments given at the hospital administration course at Northwestern University, **Everett W. Jones,** former director of Albany Hospital, Albany, N. Y., placed special emphasis on interdepartmental relationships.

Although the talk was addressed to an audience composed primarily of administrators, the suggestions offered for promoting harmonious relations not only between the heads of departments but all the way down the line were definitely pointed at the executive housekeeper.

Here are some of the highlights.

The work of the housekeeping department has a bearing on the functioning of practically every other department in the hospital.

Engineering and maintenance departments must depend on the housekeeping group for reports on needed repairs, painting and other maintenance jobs around the building.

Nursing, x-ray and physical therapy departments depend on housekeeping for cleanliness and attractiveness of their workshops.

The admitting officer depends on housekeeping for prompt servicing of vacant rooms.

Perhaps the most complicated and important relationships of the housekeeping department are those with the nursing department, including the school of nursing.

In the early days of hospitals, cleaning as well as actually ministering to the physical needs of the patients was the responsibility of the nursing department. As the folly of wasting the time of professionally trained nurses on strictly housecleaning duties became apparent to progressive and alert administrators, the purely nursing duties were gradually separated from strictly housekeeping duties.

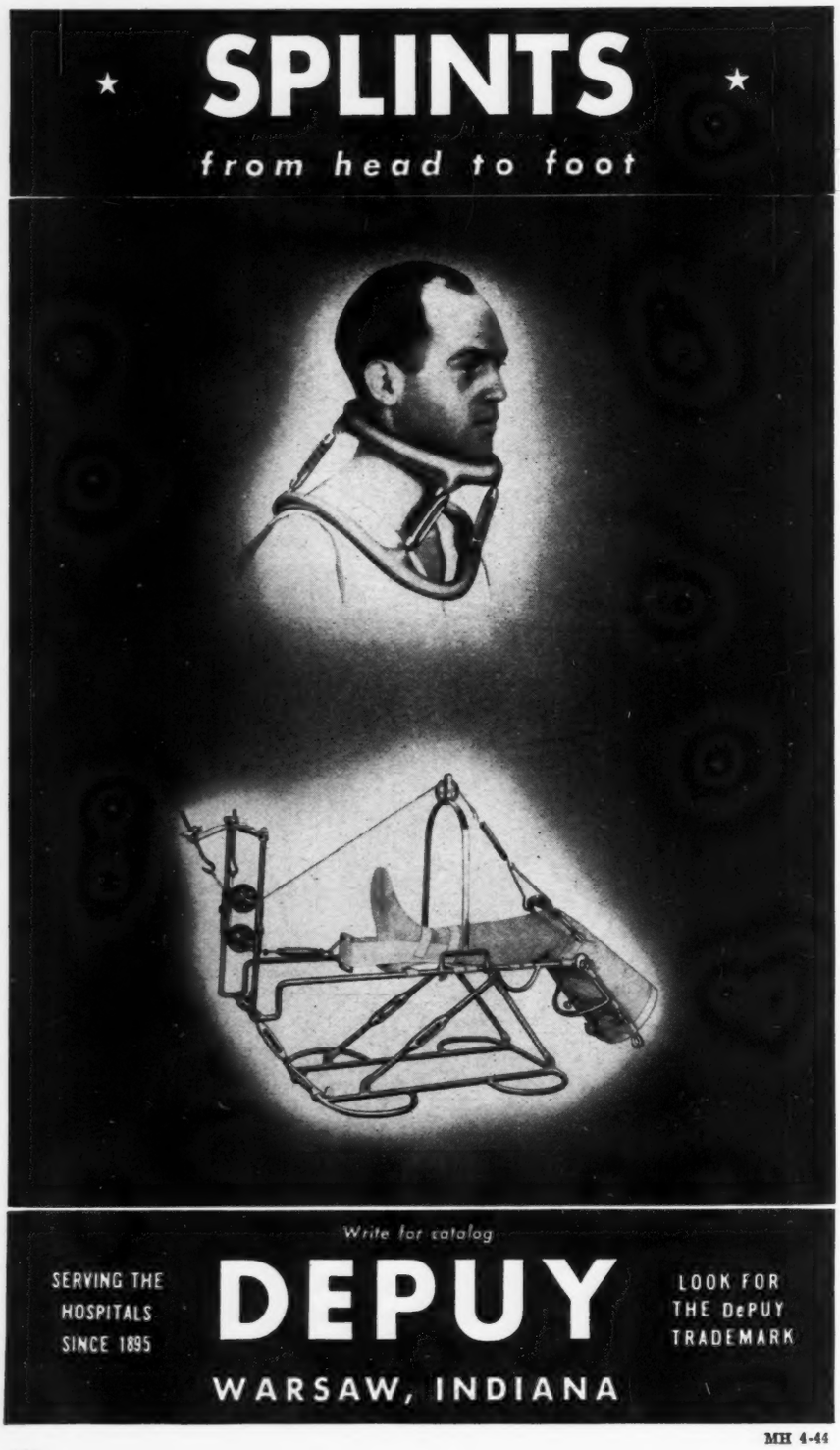
The pace of this separation was accelerated by the increasing complexity of technical and professional procedures called for from the nurses. We all recognize that the nurse of today must understand many basic scientific principles; she must be prepared to carry out and administer an ever-increasing volume of difficult professional procedures and medications requiring the use of complicated apparatus. Her education and training must keep pace with the demands of modern medicine. In short, the nurse has become an expensive product.

It follows, therefore, that this relatively expensive employe must confine her time to the professional aspects of patient care, leaving routine duties, including housekeeping jobs, to nonprofessional personnel.

Clear-cut definitions of specific duties of the housekeeping maids will go a long way toward promoting harmonious relations.

Attitudes of the superintendent of nurses and the executive housekeeper will spread down through their departments. These important executives must be in fundamental agreement. The hospital administrator is responsible for the development of cooperation between these two departments. Fortunately, the job is comparatively easy. A common-sense approach, a thorough understanding of the two departments and an appreciation of human nature will do the job.

Elizabeth Odell, R.N., director of nurses at Evanston Hospital, Evanston, Ill., offers the following practical suggestions for promoting better understanding and avoiding friction:



MH 4-44

SELECTIVE SPECIALIZATION IS
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"1. Set up definite detailed directions concerning the duties of each group. Some hospitals have a printed hospital guide containing general directions for all employes and a statement of hospital policies. In addition, a mimeographed sheet is given each new employe with more specific directions for each particular group. Modifications of these directions are explained by the head of the department to which the employe is assigned.

"2. Employes should know from whom they are expected to take orders. If possible, the orders should be given by one person in a department.

"3. In teaching student nurses, the importance of good housekeeping should be stressed and the cooperation of the students should be enlisted toward maintaining the highest standards of housekeeping throughout the hospital.

"4. There should be a friendly cooperative attitude among the heads of departments. Friction at the top permeates through the ranks.

"5. It might be explained to employes that the student nurse is a student and not a paid employe of the hospital and that the time of the graduates is needed for those duties for which they have been specially, and expensively, prepared.

"6. Even with every precaution there will still be some loopholes wherever there is the human element to deal with. Some people will be unexpectedly ill; others will not appear although they have been hired for positions on a certain day and the work still has to go on. Someone will have to go the extra mile to meet the situation.

"If the employe feels that he is working for the institution as a whole he will more often than not help out in an emergency. It does not matter to a new patient or a visitor just who is at fault if the floor is not clean and the window sill is dirty. His criticism is directed at the institution as a whole.

"7. Finally, if we can inculcate in the members of each group a respect for any work well done, no matter who is doing it, and a consideration for each other's problems, we will have gone a long way toward establishing a pleasant working relationship."

Wood Bases for Lamps

When Wesley Memorial Hospital in Chicago was opened, all of the private rooms were equipped with handsome reading lamps with porcelain bases. Unfortunately, the mortality rate on these porcelain bases was much too high to make them practical but **Mrs. Hertha McCully,** executive housekeeper, was reluctant to substitute anything less attractive.

Mrs. McCully's solution to the difficulty, which neatly reconciles beauty with practicality, was to order wood bases made on exactly the same pattern as the porcelain variety. The wood bases were then painted in pastel tints and the result is as attractive as were the porcelain models; and they have the added advantage of being unbreakable.

Housekeeper's Bookshelf

A recent addition to the literature on maintenance is **James H. Aye's** "Hand Book on Building Maintenance," published by the Continental School of Building Maintenance, San Francisco. Much information of value to the housekeeper is packed into the 125 pages of the book, which is set up as a series of 12 lessons.

The lessons deal with such problems as organizing the work; assigning the duties of the custodial staff; cleaning light fixtures, venetian blinds, lavatories and toilets, and selecting and caring for tools and equipment.

A large part of the book is devoted to the proper care of floors and at the end Mr. Aye has included a "what-to-do chart" that lists various types of flooring and the best cleaning agent, treatment and upkeep for each. ($2.

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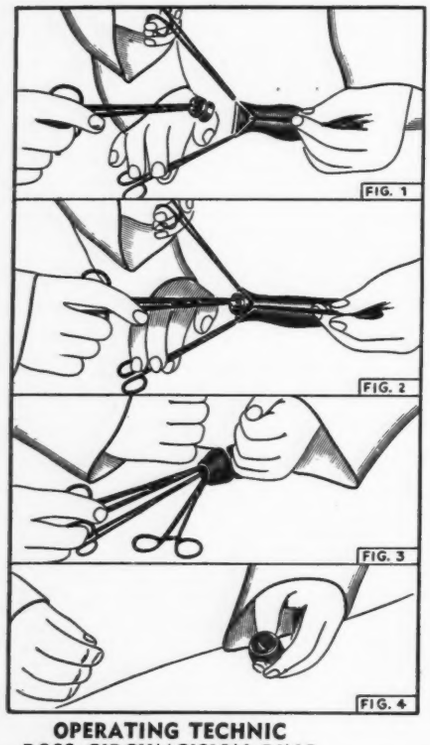

The Ross Circumcision Rings offer an improved technic of circumcision by ligation. A circumcision ring is adjusted inside the prepuce so that its external groove coincides with the desired line of amputation. Distal to the groove is an excision guide. A flange insures retention of a certain amount of the mucous membrane. The ligature is secured at the line of amputation by a surgeon's knot and the prepuce excised with scissors or knife. The ring is left in place forty-eight to seventy-two hours. The devitalized tissue protects the amputation line and falls away spontaneously later. No anesthesia is required for infants. Local and intravenous anesthesia have proven satisfactory for adults.

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* Ref. Cecil J. Ross, M.D., New Circumcision, Western Journal of Surgery, Obstetrics, Gynecology, Dec. 1940; Circumcision by Ligation, Northwest Medicine, May 1942.

OPERATING TECHNIC
ROSS CIRCUMCISION RING

Fig. 1. Introduction of instrument.
Fig. 2. Introduction of instrument.
Fig. 3. Firm application of ligature.
Fig. 4. View of penis with instrument held firmly by ligature. The prepuce has been excised just distal to the ligature.

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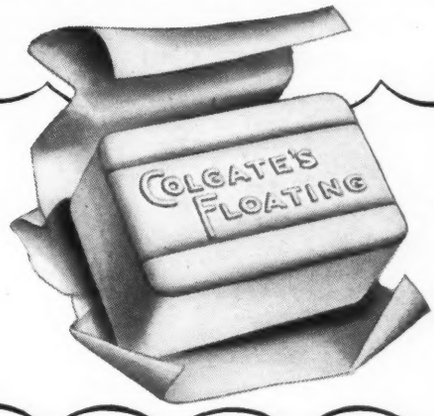

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SHALL WE CAN?

LOUISE STEPHENSON

Chief Dietitian, Grasslands Hospital, Valhalla, N. Y.

THE coming of spring reminds us of a question that many of us faced last year: "Shall the hospital participate in the nation-wide canning program this summer?" To find the correct answer many points must be carefully considered.

In the first place, the need for such a program seems obvious; food shortages grow more acute daily and the high point value of many canned foods prohibits their use. The entire production of some commercially canned foods has been scheduled for government purchase while for others the production has been limited or entirely prohibited.

From time to time, during the summer months, there will be a surplus of garden products. If the hospital staff can take advantage of such opportunities and preserve these foods for next winter's consumption, it will be making another important contribution to the war effort.

Obstacles to Be Overcome

However, lack of suitable equipment adaptable to canning purposes and the difficulties encountered in attempting to purchase new equipment, together with severe labor shortages and the lack of experience among hospital personnel in large-scale canning, are only some of the problems to be faced. These and many other factors influenced us when we were making our decision a year ago.

In spite of many obstacles we did decide to undertake a hospital canning program. It is because we feel the benefits derived from our efforts were so manifold that we shall attempt to describe briefly our simple and comparatively small undertaking.

The first question to be answered was what to can and where to obtain the products. The prices of fresh fruits and vegetables were so high it seemed impractical to buy them for canning purposes. However, there were short periods when the markets became flooded with one or more items and, as a result, prices were low for a few days. It was at such times that we purchased string beans and tomatoes for canning and in so doing helped to preserve surplus products.

Grasslands Hospital, Valhalla, N. Y., is located in the country and adjacent to the grounds there are a county home for the aged, a county penitentiary and a county jail. Much of the food consumed by these institutions is supplied by a large county-operated farm. In the past, most of the vegetables used during the summer months were produced on this farm.

In view of the acute shortage of farm labor last summer it seemed impossible to produce an extra supply of vegetables for canning. However, undaunted, the director of each institution organized his own staff and personnel as volunteers for farm labor. It was a stimulating and a reassuring sight on a summer's evening to see these volunteers, representing all departments from the three institutions, hoeing, planting and weeding from 5 p.m. until dark.

Through the cooperation of these volunteer workers with the farm superintendent and his staff, a surplus of vegetables was grown and these were available for canning. Therefore, all of the products canned during last summer's hospital canning program represented the conservation of surplus foods either from flooded markets or from extra production on our own farm.

The next question was where to obtain the extra labor needed for the canning program. Our hospital, like other institutions, was suffering from a severe labor shortage. Under these conditions it seemed unwise to undertake any program that would add to the load already being carried by our staff and personnel during their "on duty" hours.

However, we felt that a canning project could be carried out entirely by volunteer help and two sources of such manpower were available. These were, first, volunteers from our own organization who could work during the evening and, second, volunteers from among county residents who could work during the day.

The director of the hospital discussed the need for volunteers for canning at one of the regular monthly department head meetings and each member offered to canvass his own staff and personnel. The registrar in the out-patient department happened to be serving as president of the employes' association and he was appointed chairman of recruiting evening canners.

Recruited on Short Notice

Because one source of food was determined by unpredictable market conditions and the other was influenced by the uncertain weather, it was necessary for us to have volunteers who could be recruited on short notice with the least possible effort. In order to simplify and speed recruitment, department heads furnished the chairman with a list of the people who would be available on each week-day evening.

When food for canning was obtained the chief dietitian determined the number of workers needed and notified the chairman, who, in turn, called department heads who could supply volunteers for that evening.

Because she knew the number of volunteers to expect, the dietitian in charge of each canning period could plan their duties in advance, thus avoiding much unnecessary confusion among workers who were unaccustomed to working together in a hospital kitchen.

Having just enough volunteers each time was an important factor in keeping up morale. Workers who are not kept busy will not respond to the next call because they feel they are not needed. On the other hand, too few workers results in long working hours to finish the job, excessive fatigue and lack of interest for the next project.

Posters made by employes were displayed on the hospital bulletin boards. Each volunteer signed a registration book and signers were seen to count with pride the number of times their names appeared. The emergency room night attendant could not volunteer for canning so he offered to decorate the pages of the registration book with appropriate drawings and rhymes.

Refreshments Build Morale

Light refreshments consisting of a cold drink and sandwiches or cookies were served. Space was arranged in one of the dining rooms so workers could gather informally to visit while eating and resting. We found this to be another important factor in building morale.

The head of the volunteer department recruited women from near-by communities for daytime canning. She got in touch with the chairman of nutrition in the county office of civilian defense and found that canning groups were already functioning in other communities. These women were recruited to help in our program. The chairman of canteen service of the Red Cross offered the cooperation of her workers.

Local groups from these two organizations designated the days of the week they would be available and the number of people we could expect from each group. When we needed canners, we merely notified the leader of the local groups who were available for that day. Telephone calls were kept to a minimum and we knew in advance the number of workers to expect.

The women from some communities were unable to travel to the hospital by bus so, when no other means of transportation was available, the American Red Cross Motor Corps furnished a car or station wagon, thus reducing the use of gasoline to a minimum.

Another problem was suitable canning equipment. We used our regular kitchen equipment for all processes except pressure cooking. Vegetable and pot washing sinks were used for washing the vegetables. Tomatoes were blanched, to loosen the skins, in our steam cookers. Foods that required blanching before packing in the jars were heated in shallow, heavy aluminum saucepans on top of the ranges.

Jars were washed and sterilized in the dishwashing machines and preheated in a bain-marie. After the jars were filled, they were kept hot in another bain-marie until they were ready to be processed.

Acid foods, such as rhubarb and tomatoes, were processed by the water bath method in our steam-jacketed kettles. A removable wooden floor was made for each kettle. The floor consisted of 1 inch strips of wood nailed together lattice fashion to allow for free circulation of water. Autoclaves in the laboratory were used for the pressure canning of all nonacid vegetables.

We were unable to purchase jar lifters but small ice tongs were available. These were converted into efficient lifters by welding a rounded collar, which fitted the neck of the jar, to the prongs. Four such lifters and a dozen wide-necked glass funnels were the only new equipment we purchased.

Three methods of processing were used—open kettle for tomato juice, water bath for rhubarb and tomatoes and pressure cooking for all nonacid vegetables.

All of the preparation and canning except the pressure cooking was done in the hospital kitchen. The volunteers who worked during the day came at 11 a.m. By that time it was possible to have most of the preparation of the noon meal completed and a part of the kitchen could be spared for the canning operation.

Inasmuch as these workers stayed until 5 p.m., it was necessary to plan simple suppers for the hospital that could be prepared using a minimum of space and equipment. The evening canners worked from 5:30 p.m. until 9:30 p.m. During this period all the kitchen equipment was free for their use.

A production line was organized, that is, some workers washed vegetables, some cut or prepared them for canning, some filled jars, while others completed the canning process.

It was a frequent occurrence during the evening canning session to see the director of the hospital and the commissioner of public welfare working in the production line with department heads, doctors, nurses, welfare workers, laboratory technicians, attendants, cooks, porters, cleaning maids, dining room helpers and other personnel.

Space will not permit a detailed description of all steps in the canning process. We followed the directions given in the following bulletins: "Home Canning of Fruits, Vegetables and Meats," U. S. Department of Agriculture, Farmers' Bulletin No. 1767, and "Wartime Canning of Fruits and Vegetables," Agricultural Research Administration, U. S. Department of Agriculture, June 1943.

The extension services of state colleges have bulletins available, as do the home service departments of several newspapers and magazines. Local gas and electric companies may publish such bulletins.

Total Output, 3400 Quarts

A total of 85 county residents volunteered for eight daytime canning sessions and 235 staff members and employes came for 11 evening sessions. Our total output of 3400 quarts of tomatoes, string beans and rhubarb may seem small when compared with the yearly hospital consumption but we feel that our canning program taught us some interesting lessons that may be summarized as follows:

1. Inclusion of outside organized groups was a worth-while public relations venture, in addition to the working hours contributed.
2. The program afforded an outlet for employes off duty to assist in a valuable piece of work, improved the morale of employes and helped many to become better acquainted with one another.
3. Organization and advance planning proved to be of utmost importance.
4. With the benefit of a season's experience, a larger output with less work can probably be easily achieved in the next season.
5. A large pressure cooker, if available, would have greatly simplified our task, which involved using laboratory autoclaves in a location remote from the kitchen.
6. The effort was worth while on a war-time food conservation basis but not, in our judgment, as a justifiable financial economy.

Danger Lurks in the Kitchen

DON C. HAWKINS
Executive Field Representative
St. Paul Mercury Indemnity Company, Chicago

ANY effective safety program, properly organized, will be a conservation program as well and while many hospitals have effective safety programs, a number of them do not stress the importance of safety in kitchens. Before delving into this subject, certain fundamentals should be understood.

Of the many hospital kitchens I have been visiting, a large percentage has proved to be inefficient because of construction and layout, and this applies to new kitchens as well as old. This low percentage of efficiency is sad and also expensive because production costs cannot be kept at a minimum or service at the highest point of efficiency unless the kitchen is laid out with both of these features in mind.

Design Is Impractical

There is a reason for this laxness. Far too many kitchens have not been designed for practical operation, and if the institution were planned around the kitchen many of the difficulties would not occur.

It would be safe to estimate that almost any institutional kitchen could be operated just as efficiently with a lower pay roll. Size and location are the most important points to be considered. The size can be estimated only after a study of the food service requirements, number of people to be served at each meal and provisions for possible expansion.

The following are typical examples of floor space required:

Daily Service	*Floor Space Required*
100 meals	500-600 sq. ft.
250 meals	650-750 sq. ft.
500 meals	750-1000 sq. ft.
1000 meals	1500-2500 sq. ft.

It has been found advisable to have such departments as the pantry, bakery, butcher shop and dishwashing department housed in separate rooms. Naturally, the storeroom should be on the same floor as the kitchen and located close to it. If there is not space enough for a larger storeroom then it is important to provide space in the kitchen for the storage of the most frequently used supplies.

A review of the accident reports indicates that the layout of the kitchen has a definite bearing on the cause and frequency of accidents. There have been a number of accidents that are spectacular; many of them are not and their recurrence is preventable. The following is a list of accidents that have frequently occurred in kitchens:

Cuts from broken glass.

Falls on slippery floors.

Falls from tripping over obstructions.

Cuts from can openers.

Falls with overloaded trays.

Falls caused by wobbly chairs and stools.

Shocks from open electric switches.

Collisions caused by swinging or revolving doors.

Injuries from machines or equipment without safeguards.

Eyestrain caused by improper lighting.

Injuries caused by merchandise falling from shelves.

Injuries to hands and clothing caught in electric fans.

Burns from stoves, steam and hot water.

Cuts from knives with sharp edges.

Accidents destroy good will, disrupt discipline, cause important loss of time, increase labor turnover and often bring direct financial loss because of repairs, doctor bills or suits for damages. In the case of cuts especially, unless prompt measures are taken, there is an ever-present danger of infection.

The fact that insurance is carried as an essential protective feature does not mean that preventive measures should be slighted or neglected. These can be grouped in four major classifications:

1. Examination or inspection of furniture, fixtures and equipment.
2. Daily repairs of furniture, fixtures and equipment.
3. Education of employes.
4. Standardization of jobs.

With the evolution of a standardized safety program many hospitals require the head of the department to test all equipment and furnishings, such as machinery, stoves, urns, chairs, tables, fans, windows, doors and lights, at least once a month.

One superintendent reported recently: "We read your report in its entirety and each recommendation point by point; then we assigned the recommendations to the departments affected by them. Lists were made in triplicate, then each recommendation was freely discussed with the department head and with other personnel of the department so that everyone would be familiar with the recommendations and they could not be sidestepped by one person. As each recommendation is completed, a written statement to that effect will come to my desk initialed by the department head."

A mere desire to protect the patient and the employe will not get the desired results. We do not believe that this program is too detailed for actual practice and the value of frequent and thorough inspection is unquestionable.

Inspections Must Be Followed Up

However, inspections without repairs are of little value. All necessary repairs should be recorded and followed up until every piece of equipment is pronounced in perfect condition.

Many accidents can be prevented if the employes are taught to perform all their duties in the most efficient way. This means that the department manager must be the thinker and also must instruct the employes to carry out the plans.

The department head can arrange lighting, ventilating and heating so

Mary got a germ* and led her class !

*the protective wheat germ in hot Ralston cereal

FREE TO HOSPITALS!

New quantity recipes, to serve 6 or 50, using cereal in meat-saving main dishes, sugar and fruit-saving desserts, and other dishes to make ration stamps go further. Use coupon below.

Many doctors recommend hot Ralston
Because this natural whole grain cereal
Has 2½ times as much wheat germ
As whole wheat itself.
An important wartime food
Because it contains extra amounts of
Protein and vitamin B_1.
A good build-up food for patients and staff
With a grand heart-of-wheat flavor.
Economical, unrationed, easy to fix.
Available at jobbers nationally.

2 KINDS OF HOT RALSTON CEREAL
Both are Whole Grain Wheat with ADDED Natural Wheat Germ

Ralston Reasearch Laboratories
31 Checkerboard Square, St. Louis 2, Mo.
Please send, no cost or obligation, set of new 4 x 6″ quantity recipe cards.

*Name*_____ *Title*_____
*Hospital*_____
*Address*_____
*City*_____ *State*_____

that accidents from these sources become negligible. Electric switches can be closed and slippery floors can be protected with a nonskid surface. An excellent floor is red quarry or welch tile. Neither of these has a glazed surface and both have a minimum of absorption. Marble, clay tile, rubber tile or cork composition should not be used.

Efficient management demands a practical method for doing work that can be standardized. Trays should never be overloaded. It is advisable for employes to wear rubber-heeled shoes. Knives or cleavers should not be used for can openers. Mitts or cloths should be provided for handling hot kettles and, most important of all, a completely equipped first-aid cabinet should be provided in each working department. This cabinet should contain the best antiseptics, gauze bandages and adhesive tape.

Prompt and effective first aid will prevent danger of infection and may mean the saving of life itself. Manufacturers of surgical dressings provide booklets that tell in detail how to administer first aid.

It is not claimed that all accidents can be prevented. Most of them, however, result from carelessness and inefficiency or poor management.

Fire is next in importance and one little blaze may wipe out many years of work and careful planning. Most kitchen fires start from grease on the ranges or hoods above the ranges. Other causes are smoking, defective chimneys and flues, open lights and escaping gas. In this respect the following are effective preventive measures:

Smoking should not be permitted in the kitchen.

Cooks should not be allowed to burn out the chimneys by pouring old grease on a hot fire. (Stupid as it may seem, this has occurred.)

Flues should be examined carefully and cleaned thoroughly every spring and fall.

Hoods over ranges should be thoroughly cleaned at least once a month.

Tops of stoves should be cleaned every day.

Waste, oils and grease should be kept in covered galvanized iron cans.

All connections on gas and electrical equipment should be kept tight.

All wiring should be well insulated.

Grease should not be allowed to collect in ventilating pipes.

Easily operated hand extinguishers should be kept near the ranges and in every working department. Water spreads grease fires. Good extinguishers smother the flames immediately.

Accidents and fires, naturally, can be reduced through education. A safety campaign can be made successful by appealing to each employe on a selfish basis. Shortage of help is now causing difficulties and this alone will indicate the necessity of closer supervision and training.

Insurance may protect employes and property, but it can never pay for the mental strain and actual physical pain caused by accidents and fires. Violations of every suggested recommendation have been found in surveys of hospital kitchens, and a large majority of the insurance claims studied are directly traceable to violations of one or more of these rules.

The adoption of these suggestions involves no major physical changes in the kitchen and hospital heads and dietitians owe it to themselves and their employes to do all in their power to prevent loss and suffering as a result of accidents and fires.

FOOD FOR THOUGHT

"Skim Milk" Is Out

Say "nonfat dry milk solids," for the term "skim milk powder" no longer is recognized under the federal law. When the President on March 2 signed the newly enacted bill H. R. 149, years of effort on the part of dry milk producers and dairymen came to a successful conclusion.

Dr. E. V. McCollum declared in the House hearing on the bill that nutritionists recognize dry milk solids as the most valuable part of the milk. "It is our greatest undeveloped food resource."

Millions of pounds of dry milk solids are being shipped overseas and with the name "skim milk" stricken from the records the resistance of the general public to the product is expected to disappear in the postwar market.

More Spices Available

The civilian supply of black pepper and white pepper will be 6 per cent less than in 1943 but all other spices will be more plentiful, the W.F.A. announced on March 15. Packers' quotas on allspice and cloves have been withdrawn. Mace quotas have been increased from 40 to 80 per cent of the 1941 deliveries and nutmeg, from 60 to 70 per cent.

Refresher Course

A refresher course for hospital dietitians will be given from July 3 to August 11 at Teachers College, Columbia University, under the direction of Lenna Cooper of Montefiore Hospital and Nelda Ross Larsson of Presbyterian Hospital, New York City.

Because many dietitians who have been out of active hospital service are returning to institutional work to meet the shortage, it is expected that the registration for next summer's course will be heavy. The course will cover observation and experience in the management of hospital food service.

At Presbyterian Hospital emphasis will be placed on food service to patients, the food clinic, the educational program for student nurses, student dietitians and medical students and the administration of a formula room.

At Montefiore Hospital experience will be offered in menu planning, food ordering, food preparation, cost accounting, personnel management and diet therapy as applied to chronic conditions.

Trips will be made to other hospitals, including military hospitals in the area. Applications for admission should be made by May 15. Information may be obtained from Mary deGarmo Bryan, Teachers College.

More Butter During April

The W.F.A. butter release program to hospitals, begun November 15 and scheduled to end March 31, has been extended until May 1.

For the Public

Directors of food clinics may wish to distribute to their patients copies of the two color charts that appear in a four page folder entitled "Functions of Food in Nutrition" published in the interest of the national nutrition program by the National Live Stock and Meat Board, 407 South Dearborn Street, Chicago 5. The charts show the physiologic functions of the various classes of foods and important sources of food nutrients and vitamins.

This Tasty Treat Perks Up Dull Appetites at the Michael Reese Hospital

MARGARET COWDEN
Director of Dietetics
Michael Reese Hospital • Chicago

In addition to her many responsibilities at the hospital, Miss Cowden is very active in Association work. She is a former Treasurer of the American Dietetic Association and has served as President of both the Chicago Dietetic Association and the Illinois Dietetic Association. Miss Cowden finds this recipe very popular among the Michael Reese Hospital patients:

Chicken Livers en Brochette

Alternate chicken livers, mushrooms, quartered tomatoes, and half-strips of bacon on skewers. Brush with melted fat and cook under the broiler. Season and serve on triangles of Toastmaster Toast. Garnish with watercress.

Here's a typical example of how clever dietitians make wartime menu-planning easier by using Toastmaster Toast in the recipe. It's a simple way to add eye-appeal to left-overs . . . to make hard-to-get foods go farther . . . to add satisfying goodness to countless dishes. It's a quick way to add a familiar touch, because millions get the same golden-crisp, delicious Toastmaster Toast at home. And, in these days of help shortage, it's a comfort to know that your Toastmaster Toaster is never tired, never careless, never wasteful . . . makes perfect toast without watching. Send for our FREE RECIPE BOOK.

"Toastmaster" is a registered trademark of
McGRAW ELECTRIC COMPANY
Toastmaster Products Division, Elgin, Illinois

• Don't neglect your Toastmaster Toaster and it will serve you well until the Navy no longer needs the munitions we're making to help bring Victory sooner.

STRETCH HARD-TO-GET FOODS WITH DELICIOUS

TOASTMASTER REG. U.S. PAT. OFF. *Toast*

The National Habit Wherever Folks Eat!

Menus for May 1944

Helen Mae Bryan
Evanston Hospital
Evanston, Ill.

Recipes will be supplied by The Modern Hospital, Chicago

1
Stewed Prunes
Soft Cooked Eggs
•
Vegetable Soup
Pot Roast
Browned Potatoes
Harvard Beets
Tomato Salad
Baked Pears
•
Celery Broth
Macaroni and Cheese
Buttered Peas
Apple and Raisin Salad
Brownies

2
Half Grapefruit
Toast and Jam
•
Vermicelli Soup
Fricassee of Chicken
Mashed Potatoes
Stewed Tomatoes
Grapefruit and Strawberry Salad
Chocolate Pudding
•
Cream of Spinach Soup
Creole Spaghetti
Fresh String Beans
Spring Salad
Meringues With Frozen Raspberries

3
Stewed Rhubarb
Scrambled Eggs
•
Barley Broth
Lamb Patties
Parsley Potatoes
Buttered Carrots
Head Lettuce
Baked Apple
•
Tomato Broth
Creamed Sweetbreads on Toast
Fresh Asparagus
Orange, Watercress Salad
Chocolate Cup Cake

4
Orange Juice
Toast and Honey
•
Broth With Egg Drops
Baked Ham
Candied Sweets
Fresh Spinach
Fruit Salad
Grapenut Custard
•
Cream of Asparagus Soup
Individual Chicken Pie
Buttered Cauliflower
Tomato Salad
Fruit Gelatin

5
Applesauce
Soft Cooked Eggs
•
Creole Soup
Broiled Fish
Creamed Potatoes
Fresh Green Beans
Spring Salad
Fresh Pineapple
•
Alphabet Soup
Escalloped Tuna
Frozen Peas
Fruit Gelatin Salad
Iced Gingerbread

6
Baked Pears
Toast, Marmalade
•
Consommé
Roast Veal
Mashed Potatoes
Peas and Celery
Orange, Avocado Salad
Rice Pudding
•
Cream of Spinach Soup
Deviled Egg Salad
Baked Potato
Grilled Tomato
Rhubarb, Oatmeal Cooky

7
Orange Juice
Bacon
•
Tomato and Rice Soup
Broiled Chicken
Mashed Potatoes
Fresh Asparagus
Complexion Salad
Chocolate Sundae
•
Cream of Mushroom Soup
Fruit Salad Plate
Assorted Finger Sandwiches
Caramel Cake

8
Half Grapefruit
Toast and Honey
•
Alphabet Soup
Roast Lamb
Browned Potatoes
Buttered Carrots
Waldorf Salad
Caramel Custard
•
Split Pea Soup
Escalloped Noodles and Ham
Fresh Spinach
Head Lettuce
Whipped Gelatin

9
Stewed Prunes
Scrambled Eggs
•
Vegetable Soup
Ham Loaf, Orange Sauce
Baked Sweet Potato
Buttered Cauliflower
Spring Salad
Strawberry Shortcake
•
Cream of Carrot Soup
Sautéed Chicken Livers and Mushrooms
Stewed Tomatoes
Fresh Fruit Salad
Floating Island

10
Orange Juice
Toast and Jam
•
Vermicelli Soup
Chicken Shortcake
Parsley Potatoes
Buttered Beets
Banana Salad
Snow Pudding
•
Cream of Celery Soup
Broiled Cheese and Tomato Sandwich
Fresh Green Beans
Head Lettuce
Orange Sherbet

11
Applesauce
Soft Cooked Eggs
•
Broth With Egg Drops
Roast Beef
Mashed Potatoes
Fresh Asparagus
Tomato Salad
Cherry Cobbler
•
Alphabet Soup
Stuffed Green Peppers
Buttered Carrots
Grapefruit, Strawberry Salad
Prune Whip, Custard Sauce

12
Half Grapefruit
Toast and Marmalade
•
Tomato and Rice Soup
Baked Fish
Parsley Potatoes
Fresh Spinach
Perfection Salad
Lemon Pudding
•
Cream of Asparagus Soup
Mushroom Omelet
Fresh Broccoli
Tomato Salad
Baked Apple

13
Stewed Rhubarb
Bacon
•
Cream of Spinach Soup
Broiled Liver
Creamed Potatoes
Stewed Tomatoes
Head Lettuce
Meringues With Strawberries
•
Vegetable Soup
Creole Spaghetti
Fresh Green Beans
Jellied Fruit Salad
Baked Custard

14
Orange Juice
Scrambled Eggs
•
Bouillon
Roast Chicken, Dressing
Mashed Potatoes
Buttered Peas
Orange and Avocado Salad
Caramel Sundae
•
Cream of Celery Soup
Escalloped Salmon
Fresh Asparagus
Spiced Fruit Salad
Sponge Cake

15
Stewed Prunes
Toast and Jam
•
Vermicelli Soup
Baked Ham
Escalloped Potatoes
Cauliflower
Carrot and Raisin Salad
Apple Cobbler
•
Cream of Pea Soup
Jellied Cottage Cheese Salad
Baked Potato
Harvard Beets
Stewed Rhubarb
Sugar Cookies

16
Baked Pears
Soft Cooked Eggs
•
Creole Soup
Chicken à la King
Buttered Rice
Green Beans
Head Lettuce
Cherry Upside-Down Cake
•
Celery Broth
Tomato Stuffed With Macaroni and Cheese
Fresh Spinach
Fruit Salad
Floating Island

17
Orange Juice
Toast and Honey
•
Barley Broth
Roast Lamb
Mashed Potatoes
Buttered Carrots
Spring Salad
Lime Ice
•
Cream of Green Bean Soup
Sautéed Chicken Livers and Mushrooms
Stewed Tomatoes
Complexion Salad
Strawberry Shortcake

18
Applesauce
Poached Eggs
•
Tomato Broth
Veal Cutlet
Parsley Potatoes
Buttered Beets
Orange, Grapefruit Salad
Boston Cream Pie
•
Cream of Asparagus Soup
Spanish Rice
Buttered Peas and Celery
Head Lettuce
Fruit Gelatin

19
Sliced Bananas and Oranges
Toast and Jam
•
Alphabet Soup
Broiled Fish
Baked Potato
Grilled Tomato
Spring Salad
Fresh Pineapple
•
Vegetable Soup
Creamed Eggs on Toast
Green Beans
Jellied Fruit Salad
Brownies

20
Stewed Rhubarb
Scrambled Eggs
•
Vegetable Soup
Pot Roast
Buttered Noodles
Cauliflower
Apple, Grapefruit Salad
Chocolate Pudding
•
Pepperpot Soup
Asparagus on Toast, Cheese Sauce
Buttered Carrots
Tomato Salad
Meringues With Raspberries

21
Orange Juice
Bacon
•
Consommé
Broiled Chicken
Mashed Potatoes
Green Beans
Celery Hearts, Olives
Strawberry Sundae
•
Cream of Mushroom Soup
Fruit Salad Plate
Assorted Finger Sandwiches
Chocolate Layer Cake

22
Half Grapefruit
Soft Cooked Eggs
•
Cream of Green Bean Soup
Lamb Chops
Escalloped Potatoes
Buttered Carrots
Fresh Fruit Salad
Snow Pudding, Custard Sauce
•
Alphabet Soup
Escalloped Chicken and Noodles
Buttered Beets
Head Lettuce
Rhubarb Cobbler

23
Stewed Prunes
Toast and Marmalade
•
Vegetable Soup
Broiled Liver
Tea Room Potatoes
Cauliflower au Gratin
Combination Salad
Cake, Cherry Sauce
•
Cream of Carrot Soup
Spanish Omelet
Buttered Spinach
Perfection Salad
Baked Pears

24
Orange Juice
Poached Eggs
•
Vermicelli Soup
Chicken Shortcake
Mashed Potatoes
Stewed Tomatoes
Head Lettuce
Orange Sherbet
•
Tomato Broth
Macaroni and Cheese
Fresh Asparagus
Grapefruit, Strawberry Salad
Caramel Cup Cake

25
Applesauce
Toast and Jam
•
Cream of Spinach Soup
Roast Veal
Parsley Potatoes
Harvard Beets
Waldorf Salad
Grapenut Custard
•
Barley Broth
Creamed Sweetbreads on Toast
Green Beans
Tomato Salad
Cottage Pudding, Cherry Sauce

26
Stewed Rhubarb
Scrambled Eggs
•
Tomato-Rice Soup
Baked Fish
Escalloped Potatoes
Buttered Spinach
Tossed Vegetable Salad
Baked Apple
•
Cream of Mushroom Soup
Broiled Cheese and Tomato Sandwich
Buttered Peas and Celery
Fresh Fruit Salad
Iced Gingerbread

27
Baked Pears
Toast and Honey
•
Cream of Celery Soup
Lamb Patties
Tea Room Potatoes
Fresh Asparagus
Fruited Lime Gelatin Salad
Butterscotch Pudding
•
Vegetable Soup
Creole Spaghetti
Green Beans
Spring Salad
Strawberry Shortcake

28
Orange Juice
Bacon
•
Bouillon
Roast Chicken, Dressing
Mashed Potatoes
Glazed Carrots
Grapefruit and Avocado Salad
Chocolate Sundae
•
Cream of Asparagus Soup
Deviled Egg Salad
Baked Potato
Spinach
Rhubarb, Caramel Layer Cake

29
Half Grapefruit
Toast and Jam
•
Creole Soup
Roast Beef
Browned Potatoes
Cauliflower
Orange and Watercress Salad
Filled Cookies
•
Tomato and Rice Soup
Asparagus on Toast, Cheese Sauce
Buttered Beets
Tomato Salad
Fruit Gelatin

30
Orange Juice
Soft Cooked Eggs
•
Vegetable Soup
Fricassee of Chicken
Mashed Potatoes
Green Beans
Spring Salad
Apricot Upside-Down Cake
•
Cream of Potato Soup
Stuffed Green Peppers
Buttered Carrots
Banana Salad
Bread Pudding

31 Applesauce, Toast and Marmalade • Cream of Green Bean Soup, Broiled Liver, Parsley Potatoes, Harvard Beets, Fresh Fruit Salad, Rhubarb Cobbler • Celery Broth, Individual Chicken Pie, Stewed Tomatoes, Head Lettuce, Lemon Sherbet

In throat infections...

SULFATHIAZOLE WHERE IT'S NEEDED

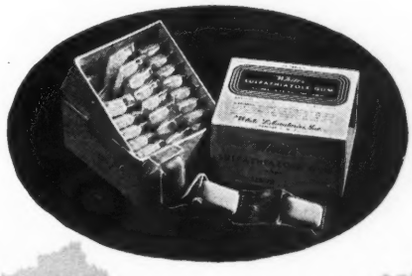
TO obtain the topical effect of sulfathiazole in certain infections of mouth and throat, without risk of untoward systemic reactions, White's Sulfathiazole Gum offers the advantages of convenience, palatability and effectiveness.

One White's Sulfathiazole Gum Tablet chewed for one-half to one hour promptly initiates a *high* salivary concentration of *locally active* (dissolved) sulfathiazole and *maintains* throughout the maximum chewing period an average topical concentration of 70 mg. per cent.

This high local concentration is accomplished despite the fact that blood levels of sulfathiazole are extremely low and for the most part not quantatively measurable.

Indications: Septic sore throat; acute tonsillitis, pharyngitis; infectious gingivitis and stomatitis caused by sulfathiazole-susceptible micro-organisms; prevention of local infection secondary to oral and pharyngeal surgery (e.g. tonsillectomy).

In packages of 24 tablets, sanitaped in slip-sleeve prescription boxes—on *prescription only*. White Laboratories, Inc., Pharmaceutical Manufacturers, Newark 7, N. J.



White's Sulfathiazole Gum

NEWS IN REVIEW

Texas Leads in State Backing of Blue Cross, Also Women's Groups

The Texas Hospital Association is blazing a new trail in American hospital activities, according to an announcement made at the annual meeting held in Dallas, February 23 and 24.

By setting up a council on hospital service plans, the Texas association becomes the first state association to throw its full weight behind its Blue Cross plan in an organized and effective way.

The purpose of this new council is to solicit full and hearty support from every hospital and physician in the state for Group Hospital Service of Texas, to interview large employers, to provide speakers on Blue Cross for every club and organization and to conduct actual enrollments if that seems advisable.

For this purpose the state is divided into 10 districts, each with a district chairman. The goal of the Texas plan is to grow from its present enrollment of 100,000 to 300,000 by the end of 1944. The subscriber contract has recently been changed to give more benefits to subscribers and to bring it more nearly into line with the uniform national contract.

The Texas convention was outstanding for two other facts: a registration of 461 (with a probable total attendance of nearly 600) and the formation of a statewide hospital women's auxiliary organization.

With the courtesy so characteristic of Texans, plaques were presented to the Methodist Hospital of Dallas in memory of J. H. Groseclose, D.D., and to the Sanitarium of Paris in honor of Margaret E. Kennedy, both of whom died during the past year. Past president badges were presented to all past presidents of the association and 10 gallon hats to Frank J. Walter and Dr. Robert H. Bishop Jr. A. C. Seawell, retiring president, was given a traveling bag.

A 10 point program for the advancement of hospital service was advocated by Mr. Walter in his banquet address. The points are: (1) improved care of the sick; (2) better educational and research activities, including public education; (3) more emphasis on preventive medicine; (4) increased development of public confidence and support; (5) expansion of hospital service so that a complete service will be available to all, including perhaps some compulsory feature such as that advocated by Governor McGrath of Rhode Island; (6) enlargement of existing hospitals and integration and coordination of facilities to make a complete system.

Other points were: (7) extension of the personal and humane values that are so fine a characteristic of our best voluntary hospitals; (8) continuance of those war-time economies that have been found desirable; (9) a governmental system for the care of indigents with responsibility first at the local level, then the state and finally, if needed, the national; (10) more united effort through local, state and national hospital associations.

New officers of the Texas Hospital Association are: president, Eva M. Wallace, All Saints Hospital, Fort Worth; president-elect, Lawrence R. Payne, Baylor University Hospital, Dallas; treasurer, Harold Prather, Wilson N. Jones Hospital, Sherman; first vice president, R. O. Daughety, Hermann Hospital, Houston; second vice president, Mrs. Alfreda P. Hassell, Medical and Surgical Memorial Hospital, San Antonio; third vice president, Sister M. Annella, St. Ann Hospital, Abilene.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REPAIRS
Bigger
THE BIG WORD — today
— in any language — in any line
Weck guarantees REPAIRS "as usu-
al" of surgical instruments on ONE
WEEK RETURN BASIS.
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REPARACIONES
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REPARATIONS
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TWO YEARS AGO this June Weck reproduced in full pages the 23-word advertisement, repeated above. The message is more timely, more vital, and more necessary today than it was then. REPAIRS — in the inimitable Weck GUARANTEED manner—mean more to Army, Navy and Civilian users today than they did in 1942 — and yet Weck still guarantees to return the instruments ONE WEEK FROM THE DAY THEY GET THEM. And they guarantee that the repairs will be done by the same skilled craftsmen.
Edward Weck & Co., Inc.
Founded 1890
Manufacturers Surgical Instruments
SURGICAL INSTRUMENT REPAIRING • HOSPITAL SUPPLIES
135 Johnson Street
Brooklyn, N. Y.

Thinking about plans for an efficient post-war kitchen? Of course you'll want the dishwashing section to be consistent with new ideas of food preparation and fine service. That's where we can help you in planning for the latest in dish-traffic methods.

Tomorrow's Colt Autosan Dishwashing Machines will make even thriftier use of space. Their flexibility of arrangement will assure speedy dish circulation in the busiest kitchens. Their capacity for fast "cloudburst action" cleansing will handle peak loads. Dishwashing time will be cut to the bone. Important, too, Autosan Dishwashers will be easy to clean—all scrap trays and spray parts being easily removable without tools.

Whether you plan to serve 100 or 2000 persons per meal, there'll be an Autosan model suited to your needs. But don't wait . . . our kitchen planning staff is ready to help with preliminary plans now so that when machines are available you'll be ready to go. Write, telling us when you would like to have one of our experienced men call to help you plan an efficient dishwashing section for your kitchen.

COLT AUTOSAN

DISH, GLASS AND SILVER WASHING MACHINES

Colt's Patent Fire Arms Manufacturing Co., Autosan Division, Hartford, Conn.

Advisory Committee to O.V.R. Holds First Meeting in Washington

WASHINGTON, D. C.—The first meeting of the professional advisory committee to the Office of Vocational Rehabilitation was held March 3. Made up of 20 specialists in medical and allied fields, the committee, appointed by Paul V. McNutt, F.S.A., will help map the new state-federal program for medical and surgical care under the Barden-LaFollette Act.

An estimated 1,500,000 persons may be eligible for rehabilitation under the program, according to Michael J. Shortley, director of O.V.R. The total active case load is 91,000 for the current year.

Plans for organization were brought to the committee by Dr. Dean A. Clark, chief medical officer for O.V.R. The committee is making recommendations for the advice of state rehabilitation agencies in the following areas of operation: the scope of physical restoration services; professional standards for physicians, hospitals and other facilities providing services under state programs; auxiliary services in the fields of medical-social work, nursing, psychiatric social work and physical therapy, and definition of the policies and plans of various groups of disabilities.

No decision was reached on the manner of compensating hospitals for services rendered under the O.V.R. program.

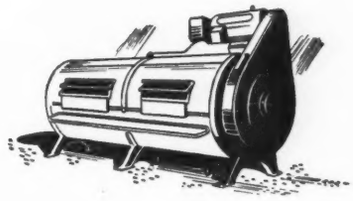
Members of the committee representing hospitals are: Rev. John W. Barrett, director of Catholic Hospitals, Chicago; Dr. E. M. Bluestone, director, Montefiore Hospital, New York City; Dr. Karl M. Bowman, president-elect, American Psychiatric Association, and medical superintendent, Langley Porter Clinic, San Francisco; Dr. E. S. Mariette, medical director and superintendent, Glen Lake Sanatorium, Minneapolis, and Frank J. Walter, A.H.A. president, St. Luke's Hospital, Denver. Dr. Donald C. Smelzer, A.H.A. president-elect, attended the meeting by invitation.

Arthritis Treatment Center Set Up

WASHINGTON, D. C.—A center for the diagnosis and treatment of arthritis has been set up at the Army and Navy General Hospital, Hot Springs National Park, Ark., the War Department announced March 2. Studies will be carried on in the use of special drugs, such as the sulfanomides and penicillin, in the treatment of this disease. Lt. Col. John Philip Hench, M.C., U. S. Army, has been placed in charge of medical service at the hospital. Colonel Hench of Mayo Clinic is an outstanding former civilian specialist and an authority on diseases of the joints.

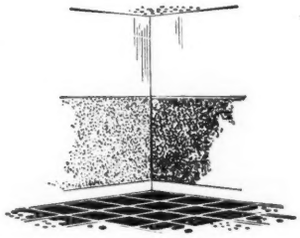
What's your score on this cleaning quiz?

Test your cleaning knowledge on these three questions. If the tips are new to you, put them into effect at once. They can help your staff make equipment and fixtures last longer . . . stay cleaner!



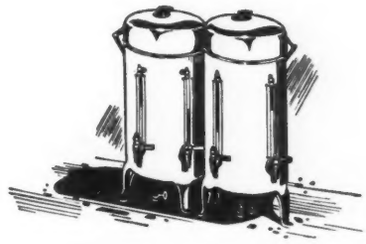
1. When laundering, what's a quick way to tell when white work is clean . . . ready to bleach?

Compare successive samples of suds waters, examining them in small, separate glass containers. A clear suds water shows load is clean, ready to bleach. Your white work gets cleaner . . . quicker . . . when you use *Armour's Flint Chips.* For *Flint Chips* yields rich, creamy suds at top temperatures . . . suds that stay active even under steam. Titer is guaranteed from 41°-42° Centigrade ...pre-proved in practical wash wheel tests.



2. How can you prevent Terrazzo from becoming "pitted" when cleaning?

"Pitting" occurs when the combination of marble chips and cement breaks down under harsh cleansers. The safest soap to use is a neutral vegetable derivative soap such as *Armour's Liquid Scrub.* Containing neither alkalis nor abrasives, *Liquid Scrub* cleans quickly, thoroughly and *safely.* Comes in convenient liquid form which dissolves instantly . . . saves time.



3. How often can you safely scour plated metals?

For safety's sake, it is best *never* to scour plated metal surfaces. Smart supervisors avoid scouring by having plated metal surfaces washed *frequently* with Armour's *Hospital Green.* It quickly floats away soil without scratching or pitting because it's a fine distilled vegetable derivative base soap containing no alkalis, no abrasives. Keep metal plating smooth and shiny with *Hospital Green.*

An Armour Soap for Every Hospital Cleansing Need

Liquid Scrub Soap
30 and 55 gallon drums

Hospital Green Soap
50 lb. tub; 200 and 400 lb. barrels

Flint Chips
110 lb. bags, 180 lb. barrels

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Bolton Act Amended; Army, Navy Hospitals Take Part in Program

By EVA ADAMS CROSS
Washington Representative, The MODERN HOSPITAL

WASHINGTON, D. C.—With the passage of an amendment to the Bolton Act, Army hospitals are prepared to give the last six months of training to U. S. Cadet Nurse Corps students in the senior period who elect to complete their course in Army hospitals, said Maj. Mary C. Walker, assistant superintendent, Army Nurse Corps, in an interview March 9.

Once the plan is well established, Army hospitals should be able to accommodate about 1500 students each six months, or about 3000 annually. The proposed hospitals are now being surveyed by their respective state boards of nurse examiners and must be approved by them, Major Walker pointed out, before student cadet nurses may be sent there.

The list of proposed hospitals follows:

First Service Command: Camp Edwards Station Hospital, Falmouth, Mass.; Fort Devens Station Hospital, Ayer, Mass., and Cushing General Hospital, Framingham, Mass.

Second Service Command: England General Hospital, Atlantic City, N. J., and Rhoads General Hospital, Utica, N. Y.

Third Service Command: Deshon General Hospital, Butler, Pa., Valley Forge General Hospital, Phoenixville, Pa., and Woodrow Wilson General Hospital, Staunton, Va.

Fourth Service Command: Moore General Hospital, Swannanoa, N. C.; Lawson General Hospital, Atlanta, and Kennedy General Hospital, Memphis, Tenn.

Fifth Service Command: Darnall General Hospital, Danville, Ky.; Nichols General Hospital, Louisville, Ky.; Billings General Hospital, Indianapolis, and Fletcher General Hospital, Cambridge, Ohio.

Sixth Service Command: Percy Jones General Hospital, Battle Creek, Mich.; Camp McCoy Station Hospital, Sparta, Wis., and Camp Grant Station Hospital, Rockford, Ill.

Seventh Service Command: Schick General Hospital, Clinton, Iowa; O'Reilly General Hospital, Springfield, Mo., and Fitzsimons General Hospital, Denver.

Eighth Service Command: McCloskey General Hospital, Temple, Tex., and Brooke General Hospital, San Antonio, Tex.

Ninth Service Command: Barnes General Hospital, Vancouver, Wash.; Bushnell General Hospital, Brigham City, Utah; Letterman General Hospital, San Francisco, and Hoff General Hospital, Santa Barbara, Calif.

The Bolton Act was also amended to enable the Navy to participate in the cadet nurse corps program. Lt. Jean Byers heads the program.

The plan is to accept annually 600 senior cadet nurses for supervised practice in six selected naval hospitals: at Seattle, Oakland, Calif., and San Diego, Calif., on the West Coast and at Chelsea, Mass.; St. Albans, Vt., and Norfolk, Va., on the East Coast.

This legislation is a war measure only and will terminate with the last class of students to start their nursing education before the end of hostilities. At the end of the senior cadet practice in the naval hospitals, the student nurses will be returned to their home school for graduation. After passing their state board examinations the cadets will be eligible to make application for acceptance in the nurse corps of the Navy.

Cancer Hospital Dedicated

Formal dedication of the new M. D. Anderson Hospital for Cancer Research, Houston, Tex., was held on February 17, with Gov. Coke R. Stevenson as guest speaker at the dedicatory dinner. The hospital, jointly financed by a $500,000 grant from the M. D. Anderson Foundation of the University of Texas and a similar sum appropriated by the state legislature, is operated by the university. Dr. E. W. Bertner is acting director.

Hamot Hospital Building Program

Construction of a 90 bed addition to Hamot Hospital, Erie, Pa., an addition to care for 55 more student nurses and expansion of laundry and kitchen facilities was begun on February 14. Federal funds totaling $280,000 have been allotted by the Federal Works Agency for the project which is expected to be completed by September 1.

Will this boy come home to find a job waiting? A job that's ready because you—and others like you—did some sound planning while he was at the fighting front?

Think for a moment of the things your community will need in the postwar period—perhaps a new hospital, or a wing on the old one.

Doesn't it make sense to plan for those improvements now—to see your architect and get all the details worked out and blueprints made—so you can start construction as soon as this war ends? It's a sure way to provide immediate jobs for your fighting men—jobs in their own communities.

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Today, hospital staffs—doctors, nurses, students and volunteer workers—are serving the needs of their communities "above and beyond the call of duty."

If that sounds like a citation for gallantry in action, then let it be considered as such.

Twenty-four hours a day, in every hospital in the land, the merciful battle goes on. The fight to save lives and bring new lives into being—with fewer doctors and nurses to help—against such added foes as longer hours, overcrowding, fatigue and nervous tension.

Yet never has there been greater need for efficiency and the calm, cheerful smile.

IN hospitals throughout the country, the soothing quiet of sound conditioning Acousti-Celotex* is contributing to the comfort and efficiency of hospital staffs.

If noise is a problem in your hospital, perhaps the nearby Acousti-Celotex* distributor can be of help to you, too. Why not call him in for consultation? He is a member of the world's most experienced acoustical organization and he guarantees results. If you cannot locate him, a note to us will bring him to your desk.

Write, also, for the *Free* booklet, "The Quiet Hospital." Reading time, 12 minutes. Address The Celotex Corporation, Dept. MH-4, Chicago 3, Illinois.

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New England Assembly Features Institute for Volunteer Workers

An all-out program for volunteers, including the first institute of volunteer service in hospitals, marked the twenty-second annual meeting of the New England Hospital Assembly. Judging from the success of the venture, the New England group has discovered the way to attract capacity audiences in war time, give them facts, plenty of facts, on volunteers. They listened attentively, hundreds of them, at the opening meeting in Boston and adjourned at lunch, only to start all over again in the afternoon with an institute exclusively for volunteers.

Never before in the history of the New England association did lay interest play so important a part in the proceedings. Instead of one trustee session, as observed in other years, the 1944 program included something for trustees at every session.

Sandwiched between discussions of how modern administrators are trained and how hospitals can be recompensed fairly for their services by a "units-of-credit" system, a lesson of the job instructor project in the training-within-industry program took place right on the stage. Setting up and taking down oxygen equipment may not be the easiest job in the world but it appeared quite simple, so effectively was it demonstrated.

Getting back to volunteers, as the program did consistently, there was no argument over the great contribution that these workers are making to hospitals in war time. The question is how their interest and support can be maintained in the postwar period. Their activities must be expanded if they are to gain satisfaction from their work.

Obviously there can be no standard pattern; each program must be built around the individual community. James A. Hamilton, director, New Haven Hospital, suggested that volunteer services might be coordinated with auxiliaries comprising not women alone but men. Prime loyalty in every individual is most important and a paid volunteer head is highly desirable.

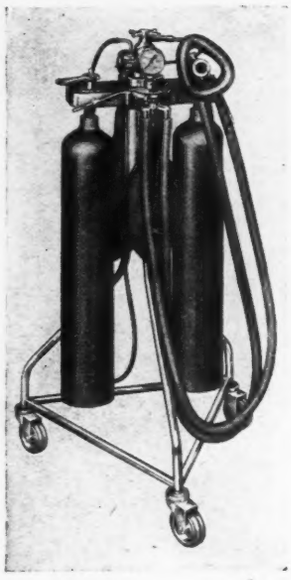
In addition to its own extremely competent family, the assembly went far afield for choice of speakers on various subjects. The story of manpower as described by Lucile Petry, R.N., director of nurse education, U. S. P. H. S.; L. Louise Baker, R.N., assistant executive officer directing nursing supply and distribution, P. & A. S., and Mary E. Switzer, assistant to the administrator, W. M. C., may not have been encouraging but no one could question its authoritativeness.

As might be expected, Boston was an important port-of-call on the crowded itinerary that Frank J. Walter, this year's A. H. A. president, has mapped out for himself. Not only was he present at the president's luncheon to express confidence in the future of the voluntary hospital system if certain challenges are met, but he sat in attendance at many of the meetings to learn firsthand of hospital affairs in New England.

Dr. G. Harvey Agnew, secretary, Canadian Hospital Council, won new advocates for his "units-of-credit" system for computing payments for hospital care, already described in these pages. Hope was expressed that this plan might be tried out in Canada first so that we might get the benefit of such experience.

It was good news to hear from Fred A. McNamara, chief of the Business Management Section, U. S. Bureau of the Budget, that the federal government has no intention of taking over any phase of hospital service where it is being run on an efficient basis and it would assist rather than hinder hospital operations.

Mr. McNamara recognized that we have a long distance to go in bringing about coordination between federal and voluntary hospitals but does see unmistakable evidences of teamwork and the development of mutual confidence. In this connection, he paid tribute to the work of the A. H A.



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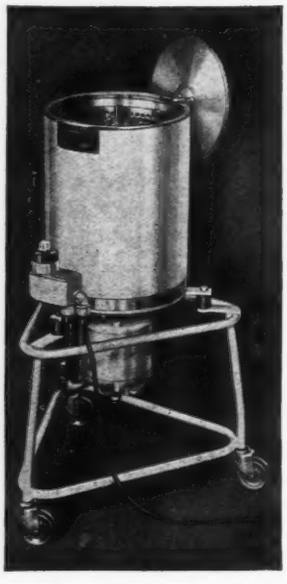

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First "E" Award and Star in the Industry.

No less surprising than the substantial attendance was the large number of exhibitors. This year the assembly had more exhibitors in attendance that at any time in the twenty-two years of its history.

From the distaff side as represented by Frances C. Ladd, superintendent, Faulkner Hospital, Jamaica Plain, Boston, the presidency of the New England Hospital Assembly goes to Oliver G. Pratt, superintendent, Salem Hospital, Salem, Mass. Succeeding Mr. Pratt as vice president is Carl A. Lindblad, director, Homeopathic Hospital, Providence, R. I. Donald S. Smith, Mary Hitchcock Memorial Hospital, Hanover, N. H., continues as treasurer, and Gerhard Hartman, Newton Hospital, Newton Lower Falls, Mass., was reelected secretary.

New officers of the Massachusetts Hospital Association are: Dr. George MacIver, superintendent, Worcester City Hospital, president; Frank E. Wing, superintendent, Boston Dispensary, vice president; Dr. W. Franklin Wood, superintendent, McLean Hospital, Waverley, secretary, and Warren F. Cook, superintendent, New England Deaconess Hospital, treasurer.

The New Hampshire Hospital Association elected Maude A. Mills, Peterboro, president; Albert F. Dolloff, Laconia, vice president; Marie Parsons, Kenne, treasurer, and Anne MacDougall, Nashua, secretary.

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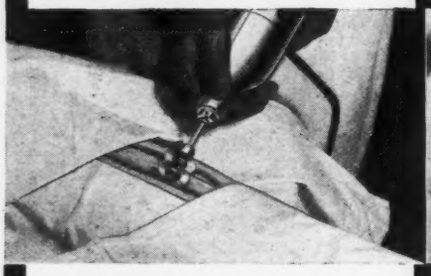
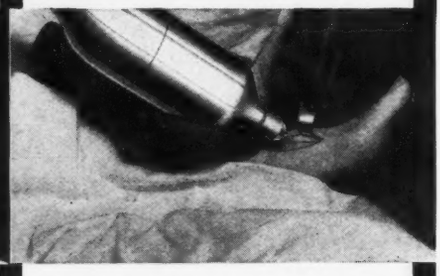
- Speeds Orthopedic Bone Surgery.
- Motor Unit and Cord Can Be Sterilized In Autoclave.

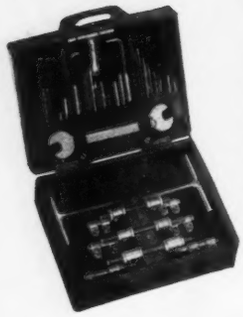
The Luck Bone Saw used with slotting burr in making transverse end cuts during removal of bone grafts, after longitudinal cuts have been made with circular saws.



The Luck Bone Saw used with twin circular saws. They rotate up to approximately 1500 revolutions per minute. Have great power. Do not jam or burn the bone. Second blade can be readily removed if only single blade is desired.



The Luck Bone Saw used with burr in cutting a graft for fusion of metatarso-cunieform joint. The cutting burr has a multitude of uses in instances where circular saws are either too large, too dangerous, or inaccessible to the operative field.



The Luck Bone Saw in fitted case with complete equipment.

● OVERWORKED orthopedic surgeons and shorthanded operating teams find the Luck Bone Saw a time and labor saving surgical aid. It operates on 110 A. C. or D. C. current. The motor unit provides a high speed of 13,000 R. P. M. at the small end, and gearing reduces speed, 6 to 1, at the other end, to which Jacobs Chuck is attached. This high speed makes possible the use of very small diameter slotting burrs. Low speed provides an ideal means for inserting Steinman Pins.

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OFFICIAL ORDERS
February 15 to March 15

Clothing.—An amendment dated February 21 to Order M-317 entirely removed the AA-4 preference rating on hospital clothing. W. S. Brines, chief of the hospital section of W.P.B., commented on this amendment as follows: "Group 3 under the AA-4 rating which bestowed priority assistance on processors to provide cloth for hospital clothing has been canceled. It was found that certain processors, while claiming priority for hospital clothing production, were actually limiting such production and illegally placing other goods on the open market. Investigation revealed that hospital clothing stocks and cloth for its manufacture were ample. Consequently, to protect the textile field, this priority was dropped. Hospitals meeting difficulty in obtaining supplies should write the hospital section, W.P.B., Washington, D. C., explaining the hardship so that steps may be taken in their behalf."

Construction.—The limit on hospital construction that can be undertaken without getting permission was raised from $200 to $1000 in a revision of Order L-41, amended March 7. In addition, certain types of construction can be done without permission and without including their cost in the $1000 limitation. The most important of these types to hospitals is insulating buildings with storm windows, weather-stripping and other insulating devices. For hospital jobs costing less than $25,000, applications should be filed in district offices; for larger jobs, they should be sent to Washington.

Electric Ranges.—A limited number of domestic electric ranges is expected to be made available for essential civilian needs in the second half of 1944, W.P.B. announced on February 16.

Food Rationing.—Hospitals that should file supplementary registration forms and fail to do so are not entitled to any food allotments until they have been filed, O.P.A. announced on March 1.

Laboratory Equipment. — Conditions under which priority assistance is given to laboratories were clarified on March 6 by amendments to Order P-43. Serial numbers, W. S. Brines explained, have been canceled for all laboratories except those whose activities are determined by W.P.B. to be highly essential to the prosecution of the war or necessary in furtherance of the war effort. This amendment explains why so many serial numbers assigned to hospital laboratories have recently been canceled. Obviously, it is felt that priorities assigned by P-43 and other orders are adequate for such institutions.

Paper Towels.—W.P.B. announced February 16 the reduction of the 1944 manufacture of paper towels for home use from 100 to 80 per cent of the 1942 base period output in an amendment of M-241-a (Pulp and Paper). Shortages of pulp account for this restriction. Still on the unrestricted production list are numerous items essential in hospitals.

Priorities.—The issuance of the bi-monthly revision of PR-3 was announced by W.P.B. February 29. It made changes in the list of items that may be delivered without regard to preference ratings and the list of items for the purchase of which blanket maintenance, repair and operating supplies preference ratings may not be used. Changes made in this revision are of no particular moment to hospitals.

Sheets.—The current shortages of bed sheets and sheeting may be alleviated through action of W.P.B. on February 14 in directing mills to produce in the same quantity as they produced for the first quarter of 1942, a peak production period. Increased quantities of 64 sley bed sheeting were also called for so as to increase supplies of lower priced sheets for nonmilitary use.

A limited increase in manufacturers' ceiling prices of bed linens was announced on February 13 by O.P.A. as part of the same program of increasing production. The price rise is about 4½ to 5 cents per sheet but no increase in consumer prices should result. Lower priced sheets should reappear in markets, Price Administrator Chester Bowles promised.

Wood Furniture.—Wood furniture manufacturers, previously permitted to make only certain types of furniture, may now produce any type they wish through an amendment to Order L-260-a dated February 26—if they can get the wood. Wood is still restricted to 83 per cent of the amount used in 1943. This is a severe reduction, according to W. S. Brines, in the face of the increased nurse housing construction caused by the cadet nurse corps.

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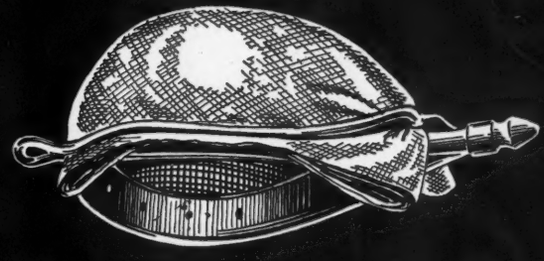

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Physicians, Lawyers Take Measures Against Wagner Health Bill

Recent activities on the propaganda front against the Wagner-Murray-Dingell Bill include the publication of the results of a public opinion poll by the National Physicians' Committee for the Extension of Medical Service, the publication of a series of editorials attacking the bill in the *Journal of the American Medical Association* and *Hygeia,* the formation of the Western States Public Health League and its repudiation by the council of the Oregon State Medical Society, the formation of the Association of American Physicians and Surgeons by the Lake County (Indiana) Medical Society and an attack on the bill by the house of delegates of the American Bar Association.

The poll of opinion was made for the National Physicians' Committee by the Opinion Research Corporation of Princeton, N. J. While the report does not say how many people were interviewed, the committee claims that the poll is "the most comprehensive study of people's opinion on medical care that was ever undertaken in the United States."

Results of the poll are summarized by the committee as follows: "This survey of opinion on medical care conclusively demonstrates that the people do not understand these issues; that, when they do understand, an overwhelming majority is unqualifiedly opposed to the proposals, but they sense the need for an extension of facilities designed to aid in meeting the costs of unusual or prolonged illness."

The committee set forth a six point program as follows: (a) to encourage the medical profession to active participation in the development of prepayment plans; (b) to educate the people to use existing prepayment plans; (c) to urge industry to participate with employes in prepayment plans; (d) to inform private insurance underwriters of opportunities in this field; (e) to encourage state and local rather than federal subsidies for medical care for the indigent, and (f) to encourage larger financial contributions to the committee's program.

The Western States Public Health League was formed on December 11 at Salt Lake City by representatives of Arizona, California, Colorado, Idaho, Oregon and Utah state medical societies.

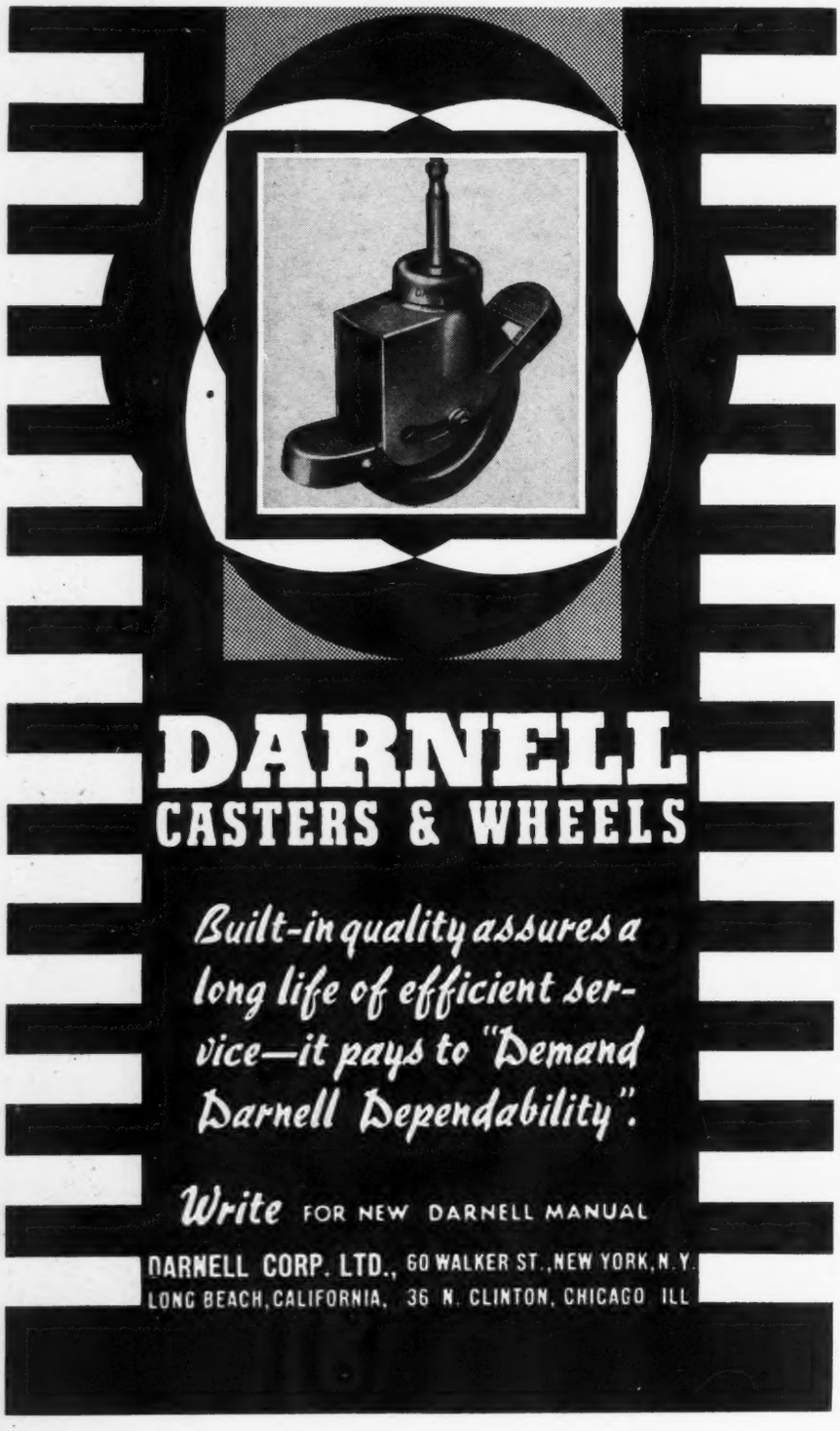
The Oregon State Medical Society, however, published a letter in the February issue of *Northwest Medicine* repudiating any inference that that society is a member of the league.

The league proposes to maintain a service bureau in Washington, D. C., to inform governmental agencies regarding public health matters affecting the western states.

The new Indiana sponsored organization seeks to enroll doctors who will pledge themselves to refuse participation in any scheme which their group regards as inimical to the best interests of patient and physician.

The association will make an all-out fight on the Wagner-Murray-Dingell Bill and will sponsor voluntary prepayment plans for medical service. A Washington office will be established.

The American Bar Association's attack on the bill was based on six objections: depreciation of local self-government; centralization of authority in the surgeon general; control over citizens, hospitals and doctors by the federal government; failure to safeguard the rights of patients, citizens, hospitals and doctors; lack of appeal from the actions of the surgeon general, and lack of court review.



Greenwich Issues News Letter

A news letter designed to keep its staff members in service at home and abroad in touch with the activities of Greenwich Hospital, Greenwich, Conn., made its first appearance in February. As yet unnamed, the "letter journal" was the inspiration of the chief engineer, Alexander Mackail.

Double Deck Bunk No. 333

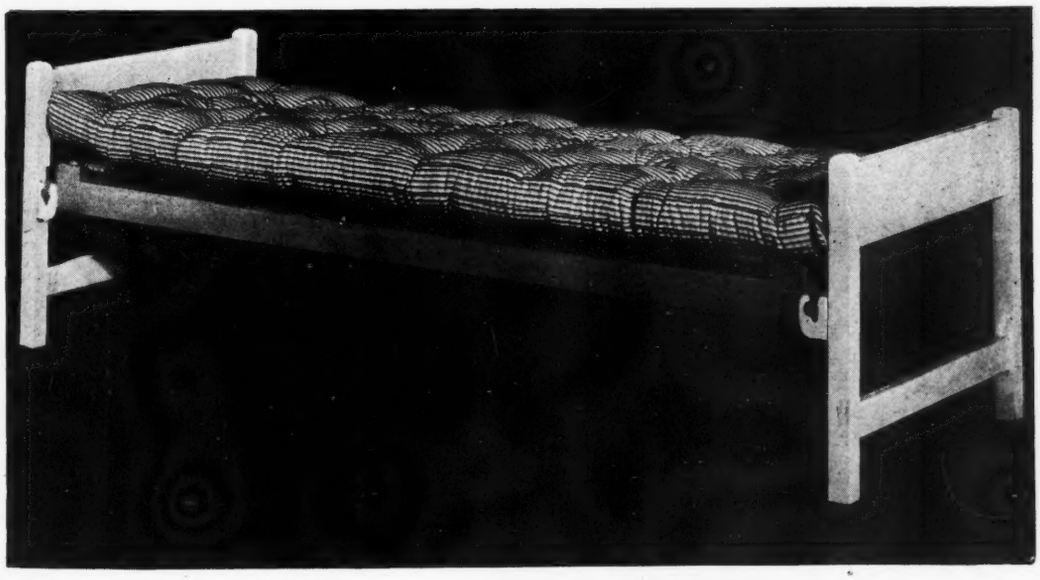
Double Deck sleeping arrangements are the solution for overcrowded conditions. Our No. 333 Bunk is very strong and rigid, being built of the finest hardwood. Better still, it is remarkably comfortable, having a very good spring and an extra thick Felt Mattress.

We have a limited stock finished in Walnut.

If interested, write us for full particulars and prices.

Another mighty useful little bed is No. 300. It is 2 ft. 6 in. wide, made of the finest hardwood and has strength and rigidity. The spring is very comfortable and, with a good felt mattress, it makes a First Aid Room Couch or a Dormitory Bed of unusual quality.

The price is very modest.



Nurses' Bed No. 300-54W

Write for full particulars to:

Hard Mfg. Company, Buffalo 7, N. Y.

First Institute on Personnel Management Will Be Held at Yale

A five day institute on hospital personnel management, the first of its kind, will be held at Yale University from June 26 to 30, inclusive. It will be conducted by the A.H.A. committee on personnel relations with the cooperation of Yale University and the New England Hospital Assembly. James A. Hamilton will be director.

The program will deal with the following subjects: nature of personnel problems, selection and placement, labor turnover, stimulation of interest, transfer and promotion, training, wages and financial incentives, employes' health service, physical environment, hours of employment, living conditions, aged workers and pensions, absences and tardiness, accidents and their prevention, handling of grievances, labor legislation, collective bargaining, organization for personnel management, government regulations affecting personnel and personnel shortages and how to meet them.

The faculty will be composed of leaders from hospitals, universities, industry and government.

Students eligible to attend are hospital administrators and, when recommended by their administrators, assistant administrators, personnel directors and other hospital department heads. Enrollment will be limited. Lectures and seminars will be held at Sterling Divinity School of Yale University. Meals and housing will be available there and in near-by fraternity houses.

The tuition fee is $25 and costs of meals and housing are estimated at $25. Application forms are available from Dorothy Hehman, secretary of the institute, New Haven Hospital.

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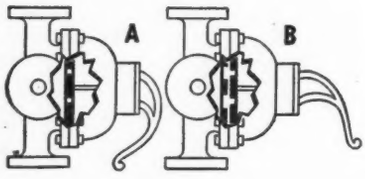
All operations are controlled by one valve—backwashing, regeneration, softening to service. The complexity of an entire manifold of valves is reduced to the simplicity of a single control lever. Unlike most multi-port types, in the Refinite Solo Valve the solid bronze stem plate is lifted entirely free from the resilient disc, on which it is normally seated, when it is moved to a different position. This eliminates any possibility of scoring or sticking of parts. It is completely leakproof because the valve closes on a resilient disc of very long life. A built-in brine ejector, and built-in backwash control are a part of every valve. The features of the Refinite Solo Valve are so important to you as to make them subject to serious consideration when a water softener installation is contemplated in your plant.

Illustration at right (Fig. B) shows position of stem plate in relation to resilient disc when valve is opened to be indexed to different position. Notice space between them. No friction, scoring or sticking. Fig. A shows valve closed.



Discuss your water problem with Refinite. There's no obligation.
Write Refinite today!

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Write for Free Catalog **105 Refinite Bldg., Omaha, Nebr.**

W.F.A. Revises Handling of Free Food in Institutions

A revised system of handling free food in the institutional field has been devised by the War Food Administration, the Joint Purchasing Corporation, New York City, announced March 15.

The primary conditions of the plan are:

1. Commodities received from the Food Distribution Administration will be used to supplement foods normally purchased by the beneficiary institutions and not substituted therefor.

2. Commodities will be requested by institutions strictly on the basis of non-paying patients, *i.e.* patients who personally contribute nothing toward their care and sustenance while they are residents of the institutions.

It is pointed out by the purchasing corporation that, apparently, applications for free food can be made only on the basis of patients who receive free care and those who are paid for by the city or state. Formerly, no distinction was made among various types of patients and applications for free food were made on the basis of the number of beds in an institution.

New President of Nebraska Plan

Francis J. Bath, business manager of St. Joseph's Hospital, Omaha, Neb., was elected president of the Associated Hospital Service of Nebraska at the annual board of directors' meeting. Entering its sixth year of service, the plan has more than 25,000 members and 21 hospitals enrolled as member institutions.

Leaves $10,000 to Build Hospital

An estate of nearly $10,000 was bequeathed by Lars Olson, who died December 28 at the age of 80, to Kelliher, Minn., to found a hospital. Under the terms of the will, a trustee was instructed to pay all monies remaining after deducting burial and other expenses to a nonprofit corporation organized to form a hospital in this village, provided an equal amount was raised within ten years.

Efficiency in Equipment that Matches this Fine Hospital..

CHILDREN'S HOSPITAL, Denver, Colo.
Architect: Burnham Hoyt, Denver.
Contractors: Brown-Schrepferman & Co., Denver.
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Kewaunee Equipment in Children's Hospital, Denver, Colo., includes:

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For many years Kewaunee Manufacturing Company has served in a helpful capacity to America's leading Architects and Contractors in the construction and equipping of fine Hospitals. The Children's Hospital of Denver, Colorado is a splendid example of modern design, construction and equipment.

It is the responsibility of Kewaunee's engineers to bring to each job nationwide experience and helpful service rendered without extra charge. Remember, you get much more than fine scientific equipment when you choose—

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British Government Offers New Postwar National Health Scheme

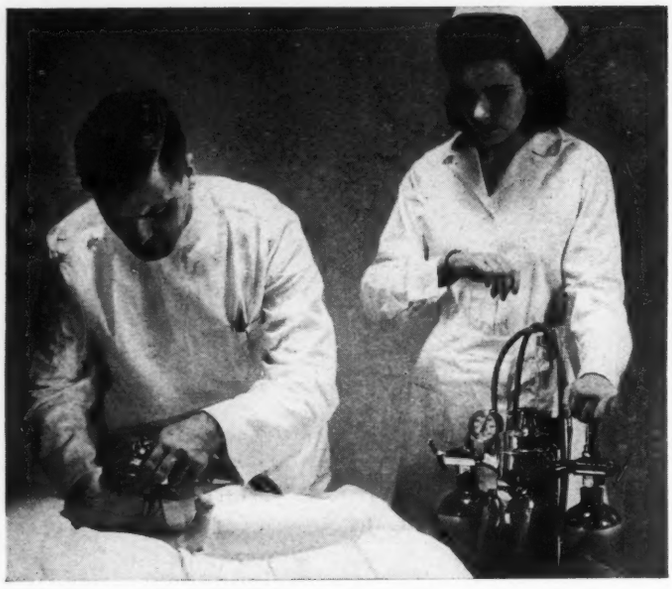
The British Government on February 17 proposed in an official White Paper a postwar national health scheme envisaging free medical and hospital service for everyone in the country at a total cost estimated at $592,000,000 annually. The best medical facilities would be available without regard to the patient's ability to pay.

The government stated that the people would be free to use the facilities or not as they wished and physicians would be free to enter the scheme or not. Physicians could practice in groups or singly.

The plan was described by one reporter as an ingenious compromise between the existing system and all-out state medical service. He said the plan was "fundamentally sound and very provocative."

Lord Dawson, president of the British Medical Association, said the plan was a "genuine statesmanlike endeavor to meet an extremely difficult position." Among the questions needing to be worked out, however, he mentioned the future of the voluntary hospitals and the contributory schemes.

The minister of health, Henry U. Willink, stated that the voluntary hospitals "will work on a basis of full partnership with the publicly owned hospitals. The treatment provided patients will be on exactly the same basis."



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PIONEERS AND SPECIALISTS IN MECHANICAL ARTIFICIAL RESPIRATION

Cadet Nurse Corps "Pledges" High School Juniors, Seniors

WASHINGTON, D. C.—U. S. Cadet Nurse Corps membership cards are being sent to all participating schools of nursing, according to an announcement March 8 by Lucile Petry, director, Division of Nurse Education, U. S. Public Health Service.

Two additional forms accompany each certificate, a record card which will enable the Division of Nurse Education to classify all members of the corps by state, school and class, and a questionnaire to provide data for statistical and public information purposes.

A U. S. Cadet Nurse Corps pledge program has been sponsored by the U. S. Public Health Service, the F.S.A. and the National Nursing Council for War Service.

While the program does not guarantee that pledges will become members of the cadet nurse corps, it is designed to supply a constant flow of new cadet nurses to schools of nursing. Good health and good scholastic standing in the junior or senior class of an accredited high school are minimum requirements.

Veterans Facilities for 100,000 by 1946

WASHINGTON, D. C.—The Veterans Administration has estimated that its present construction program will change the capacities of various types of facilities in the period from Dec. 31, 1943, to Dec. 31, 1946, as follows: tuberculosis beds, 6626 to 8093; psychiatric beds, 38,075 to 55,917; other neuropsychiatric beds, 2572 to 2511; general beds, 20,310 to 21,884; total hospital beds, 67,583 to 88,405; domiciliary beds, 16,303 to 13,117; grand total of all beds, 83,976 to 101,522. In the figures for Dec. 31, 1943, there are 6070 emergency beds included.

Philanthropy Increases

A 54 per cent increase in philanthropic gifts contributed in large cities of the country during 1943 was reported by John Price Jones Corporation, New York City. Large philanthropic gifts recorded in the press in New York, Chicago, Philadelphia, Baltimore, Boston, St. Louis and Washington totaled $120,846,785. Of this sum, $3,925,156 was contributed to health agencies, which was an increase of 20 per cent over the total for 1942 but below the 1941 figures.

Andreas Vesalius——————————*1514-1564*

Convinced of the validity of his ideas and driven by a desire to sweep away old errors, this great anatomist firmly renounced medical beliefs based on superstition and tradition, thus creating the foundation of modern medical science based on facts. He undermined the false structure of previous anatomical pronouncements, and labored to make anatomy a living, working science. Crowning his achievements, he brought forth an epoch-making book which still enjoys an eminent position as a valuable and practical anatomical text.

The world of medicine will ever be grateful to this far-sighted rebel, for not only did he contribute great new truths—he also demonstrated how necessary is the spirit of independent observation and research to the advancement of medical science—a fact fully understood by surgeons of today.

In this spirit, an increasing number of modern surgeons advocate the use of silk for visceral, soft tissue and skin suturing. For their safety and fine handling qualities, CHAMPION-PARÉ Silk Sutures are preferred by many of them. These sutures are *Moisture-* and *Serum-Resistant* . . . will not become a focus of infection. Because of their great tensile strength, fine diameters may be used, conserving tissue vitality and allowing rapid healing. They are soft and pliable, making them easy to handle—strong and firm, preventing slipping and curling.

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A.C.H.A. Announces New Type of Educational Conference

A new type of educational conference on hospital administration and recent social trends, open only to fellows of the college, was announced on March 17 by the American College of Hospital Administrators. The first such conference will be held April 25 to 28, inclusive, at the Center for Continuation Study, University of Minnesota. Only 40 fellows will be accepted as registrants.

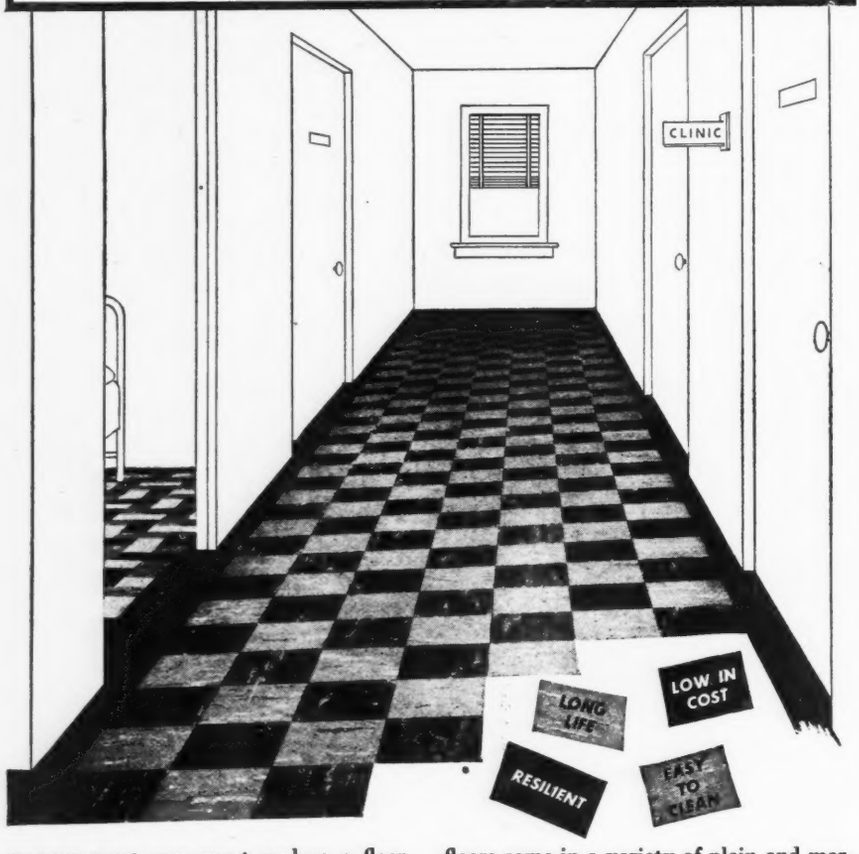
The conference will seek "to clarify the thinking of the intelligent professional man about such questions as: What is the significance for our social order of government debt? Of the tax burden and its distribution? What are the real dangers of inflation and its resulting effects? What is the significance of the distribution of national income and of changes in that distribution? What is the American 'standard of living' and what proportion of it is or ought to be considered as subsistence costs?

"What is the significance of the present trend toward government control of business enterprise? What importance for our social order has the contest between individualism and statism, between local government activities and centralized federal activities? How have changes in technology and in social thinking affected the public attitude toward medical and social scientific services."

Lecturers and discussion leaders will be selected from the faculties of the University of Minnesota and other universities and will represent the fields of economics, political science, psychology, public health and sociology. Tuition is $25.

HOSPITAL FLOORS

can be lower in cost, longer lasting, easier to clean



NEXT TIME you must replace a floor, consider the advantages of Johns-Manville Asphalt Tile. Made of asbestos and asphalt, it will last for years, even under severe scuffling and constant traffic.

J-M Asphalt Tile is also quiet and resilient underfoot. It helps reduce fatigue of busy nurses and attendants. And, of prime importance these days of hospital-help shortages, J-M Asphalt Tile is quick and easy to clean and maintain.

Prewaxed at the factory, the flooring is ready to use as soon as it is installed. J-M floors come in a variety of plain and marbleized colors which permit an almost endless number of designs and color schemes.

You will like the J-M marbleizing. It has the interesting veining of real marble and avoids any feeling of mechanical regularity often found in ordinary floors.

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Greater New York Fund Starts Annual Fund Drive

General chairmanship of the 1944 fund-raising campaign of the greater New York Fund has been accepted by J. Stewart Baker, chairman of the board of the Bank of the Manhattan Company.

The annual drive, seventh since the fund's inception, will start April 18 and will seek to raise funds for local voluntary hospitals, welfare and health agencies. In 1943 the drive obtained a total of $4,333,980 in contributions and pledges which was distributed among the 406 organizations affiliated with the fund.

The appeal is annually directed exclusively to business concerns and their employes.

Lectures on Hospital Planning

"Hospital Planning" is the theme of a series of 15 lectures sponsored by the New York Chapter of the American Institute of Architects and the New York City bureau of architecture, which began on March 3 and will continue through June 9. The lectures, covering such subjects as comprehensive planning, nursing units, administration, diagnostic and therapeutic departments, special hospitals and mechanical plant, will be given by Isadore Rosenfield, chief hospital architect of the New York Department of Public Works, and other speakers. All persons interested in the many aspects of hospital planning are eligible to attend the series. The cost of admission is 50 cents for each lecture.

Montreal Hospital Celebrates

Celebration of the golden jubilee of Royal Victoria Hospital, Montreal, and of the centenary of Royal Victoria Montreal Maternity Hospital was climaxed by a reception held in the assembly rooms of the nurses' home on the evening of March 8. Present at the reception were the governor-general of Canada, the Earl of Athlone, and Her Royal Highness, the Princess Alice, honorary president of the auxiliary board. During a two day visit to the hospital Princess Alice formally opened a new nursery in Montreal Maternity Hospital.

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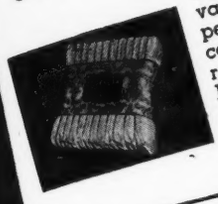

Made in various types to meet various needs and budgets. Superior absorption capacity, soft, comfortable, anatomically correct, sterilizable and disposable. Economical too. Used under various brand names in commercial, industrial and field hospitals.

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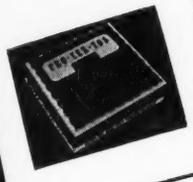

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LABORATORY experimentation on Sterilek sanitary essentials and surgical dressings never ceases. And, as soon as new worthwhile improvements are evolved they are promptly incorporated into Sterilek products . . . to make them even better than before. Only in this way, the company believes, can Sterilek keep in stride with advancing medicine and surgery.

To match the progress of the laboratory technicians, Sterilek production engineers are ever on the alert to facilitate manufacturing processes and effect other operating economies which are passed on to Sterilek customers. Small wonder then that within less than a quarter of a century the name Sterilek has come to mean dependable quality at equitable prices to so many hospitals and industrial clinics.

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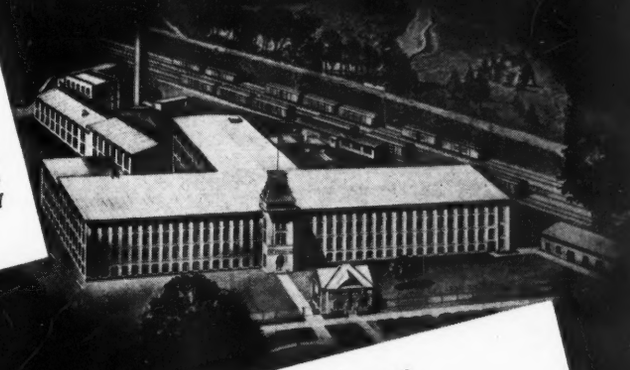
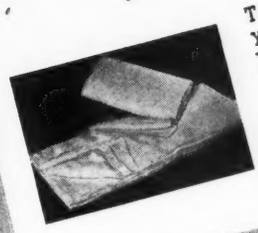


Absorbent Gauze



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New Hampshire Blue Cross Plan Extended to Vermont

Extension of the New Hampshire Hospitalization Service to serve Vermont was announced in the March issue of *News and Notes,* a monthly publication of the New Hampshire Blue Cross, the New Hampshire Hospital Association and the Vermont Hospital Association. A central office will serve both states.

James M. Langley of Concord, N. H., was elected president of the extended plan which will now be known as the New Hampshire-Vermont Hospitalization Service. Four Vermont representatives were elected to the board of directors. Russell Spaulding is the manager.

Reciprocity legislation was enacted by both states to make this arrangement official and the Vermont Hospital Association invited the New Hampshire Hospitalization Service to extend its area. The estimated 1942 civilian population of the two states is 817,000.

Steps are being taken by the New Hampshire Medical Society to establish a corporation to provide medical and surgical service. It is expected that enrollment for this service will be handled by the Blue Cross organization.

The New Hampshire Farm Bureau has set up an organization for the enrollment of farmers in the state and more effort is to be devoted to reaching smaller communities and rural areas during the coming year.

Methodist Group Discusses Ways of Retaining Employes

Favorable results in retaining employes by paying a bonus to those who stayed a full year were reported at the annual meeting of the National Association of Methodist Hospitals and Homes in Indianapolis on February 18 and 19.

In the discussion following this report it was suggested that such payments be labeled "adjusted compensation" instead of bonus to remove from the minds of the public the idea that payment of a bonus had resulted from profits in operation.

Increases in property values and endowments of the various Methodist institutions were disclosed by the Rev. John G. Benson, superintendent, Methodist Hospital, Indianapolis.

The need for training programs for supervisors and department heads in hospitals so that they, in turn, can do a better job of training and educating employes was strongly emphasized by Dr. Clyde S. Wildman, president of DePauw University at the Saturday luncheon meeting. Banquet speaker was Dr. Roy Smith, editor of the *Christian Advocate,* whose theme was the spiritual values necessary in the successful operation of hospitals.

Penicillin Production Speeded

WASHINGTON, D. C.—Nineteen major penicillin producers in the United States and two from Canada met in Washington March 14 to explore the possibilities of obtaining a rapid increase in the production of penicillin. Officials explain that if all firms manufacturing penicillin could be brought up to the rate of the most efficient the problem of adequate supplies for war needs would be largely met. When full production is reached at the new $1,750,000 plant in Terre Haute, Ind., 40,000,000,000 units of penicillin will be produced monthly.

Accounting Institute in June

The third annual accounting institute will be conducted by the A.H.A. committee on accounting at Indiana University, June 26 to 30, according to an announcement on March 17 by George P. Bugbee, executive secretary of the A.H.A.

Tuition is $15 for the course. Dates for the third annual purchasing institute have not yet been set but it is fully expected that such an institute will be held, Mr. Bugbee stated.

A "Serving OF FRESH VEGETABLES"

...IN EACH GLASS OF NUTRITIOUS V-8 *

★ A serving? Yes, indeed! Because the natural juices of garden fresh ★ lettuce ★ carrots ★ beets ★ celery ★ spinach ★ tomatoes ★ parsley ★ watercress are used to produce one glass of delicious V-8 Vegetable Juice Cocktail. Just the merest pinch of seasoning has been added. This special combination of these vital juices makes a delectable "helping" of leafy green, red and yellow vegetables in their tastiest form — nutritious, satisfying, refreshing. V-8 is pasteurized (not cooked) and contains Vitamins A, B_1 and C, calcium and iron. Keen sluggish appetites on drowsy spring days with tantalizing V-8. Serve it — with meals and in between too! This wholesome beverage, either hot or cold, is ideal for adding new interest to meals in a tempting, tasty way . . . supplying vegetables a new, easy way . . . vitamins the natural way. Keep a good stock. Serve vegetables the V-8 way to patients and staff members every day.

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Quantity recipes for tasty, practical dishes that stretch and save points. Instructions are complete with quantities and weights on ingredients. Write to Standard Brands Incorporated, Dept. V-8Q, 595 Madison Avenue, New York 22, New York.

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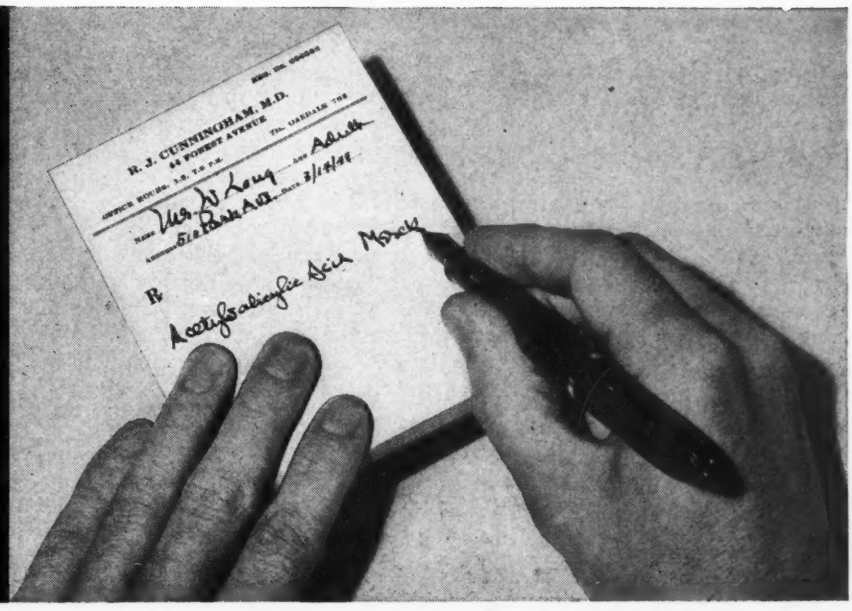

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Because of the care and integrity with which every product is made or formulated, the physician who specifies Merck Prescription Chemicals can do so with complete confidence in their purity, uniformity, and reliability.

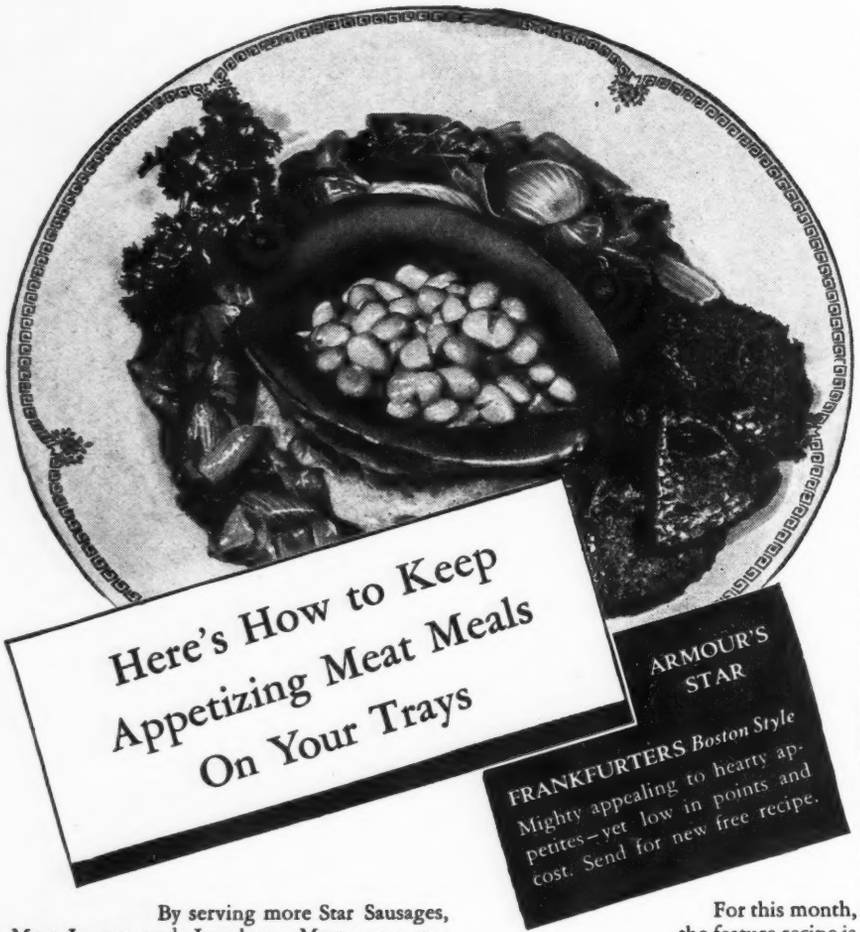
MERCK & CO., Inc. *Manufacturing Chemists* RAHWAY, N. J.

Train Administrative Officers as Aides to Battalion Surgeons

WASHINGTON, D. C.—Some 200 or 300 officer candidates of the School for Administrative Corps officers are in training at the Medical Replacement Training Center, Camp Barkley, Tex., it was learned in an interview at the surgeon general's office of the War Department, March 2.

The school will train officer candidates as assistants to battalion surgeons. This training is part of a program to make more effective use of medical officers and it is designed ultimately to relieve hundreds of them for more professional duties.

Since the duties of an assistant battalion surgeon, now captains or first lieutenants of the medical corps, consist principally of giving emergency treatments, such as administration of plasma, checking a hemorrhage and dressing wounds, it is now proposed to replace the medical officer assistant surgeon with a medical administrative corps assistant to the surgeon. A six weeks' highly intensified course is given. Enlisted men who have had medical technical training in the Army or who in civilian life were male nurses or pharmacists are especially desired for this training.



By serving more Star Sausages, Meat Loaves and Luncheon Meats, you can give your patients satisfying meat meals every day. These fine low-point meats help stretch your meat rations and there's a wide variety from which to choose.

To help you with your wartime menu problems, Armour will send you free quantity recipes each month, showing how to prepare new entrees with Armour's Star Sausages, Meat Loaves and Luncheon Meats. These recipes are created by Jean Lesparre, Armour's internationally famous chef, who knows your problems and can help you save work, cut down costs, and stretch your rations.

For this month, the feature recipe is Armour's Star Frankfurters Boston Style—a hearty, flavorful meal that's easily prepared. It's sure to be popular with patients, for Armour's Star Frankfurters are always tender, always tasty. Made of fine beef and pork, carefully blended with delicate seasonings to bring out their rich meat goodness.

To get recipe for this meal and other free quantity recipes featuring Armour Sausage and Luncheon Meats, write to Hotel and Institution Department 24, Armour and Company, Union Stock Yards, Chicago.

Armour and Company

Bed Shortage in Washington Eased by Suburban Building

WASHINGTON, D. C.—Opening of three new suburban hospitals, streamlined and up to the minute in equipment and furnishing, has done much to relieve the critical shortage of hospital beds and facilities existing in the Washington metropolitan area.

Trim new brick hospitals already operating in Bethesda and Cheverly, Md., and in Arlington, Va., have eased the strain on city hospitals.

More than 550 patient beds plus nurses' quarters, equipment and other hospital facilities have been provided with approximately $3,600,000 of Lanham Act funds from F.W.A. for new hospitals in Montgomery and Prince Georges counties, Maryland, and Arlington, Va. Sundry enlargements embracing additions to Gallinger Municipal Hospital, improvements to Georgetown University Hospital and extensions to Alexandria Hospital are included in this list of achievements.

Billboards Publicize Cadet Nurse Corps Program

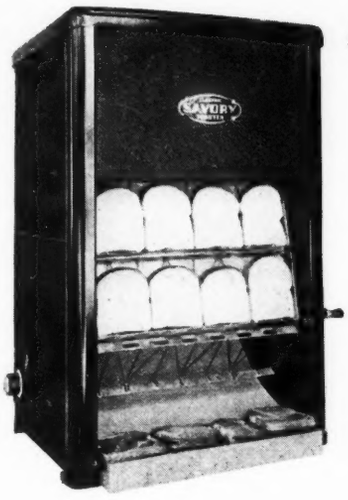
Through the cooperation of the General Outdoor Advertising Company, 257 billboards in northern Minnesota now proclaim to prospective students the advantages of joining the U. S. Cadet Nurse Corps. Steps are also being taken to erect similar billboards in the southern part of the state.

The project, first of the kind in the country, is part of the public education program worked out jointly by the Minnesota Hospital Association, the Blue Cross plan and the Minnesota State Nurses' Association.

Margaret Reagan, public education director for the Blue Cross plan, devised the billboard campaign.

1943 Nursing Facts Issued

Sixteen additional pages of information are included in the 1943 edition of "Facts About Nursing," recently issued by the American Nurses' Association. Included in the booklet are data on the number of nurses in the country, the number serving with the armed forces, incomes of nurses, variations in cost of living in different sections of the country and the number of licensed auxiliary workers in nursing services. Copies can be obtained at a cost of 25 cents from the Nursing Information Bureau, American Nurses' Association, 1790 Broadway, New York City 19.



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When Uncle Sam needed toasters for our armed forces, Savory was privileged to help fill that need.

Uncle Sam wanted . . . and *got* . . . the finest toaster made.

For Savory's is a two-fold excellence: *it makes more delicious toast . . . less expensively.*

Savory's exclusive *pre-cooking* process gives each slice a soft, tender, center. Then, as it is evenly browned, each tender slice acquires Savory nut-sweet crispness.

And each Savory Toaster—electric or gas—operates for pennies per hundred slices because of scientific construction and automatic controls.

You, too, need a Savory Toaster in *your* business. And the chances are you can get one right away. For Uncle Sam, knowing the home-front importance of toast, is allowing many civilian food service operators to get their Savory Toasters *now*. Why not ask your dealer or write us? You won't be obligated, of course.

Shown at top is the SAVORY P.Q. model, gas operated, 540 to 720 slices per hour. All electric toasters also available. Also smaller models.

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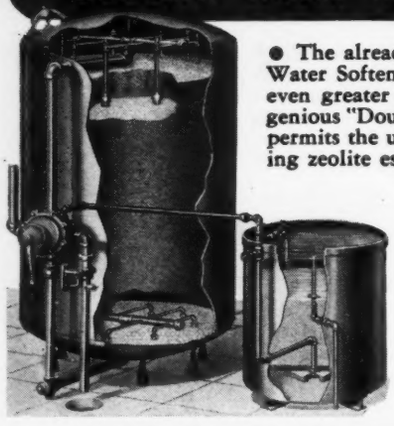

● The already well-established Elgin "Double-Check" Water Softener has been further improved to provide even greater softening capacity and efficiency. An ingenious "Double-Check" manifold system, as illustrated, permits the use of a far deeper zeolite bed by preventing zeolite escape. Compared to the ordinary softener, it will give up to 44% more soft water capacity. Substantial savings are the result. More than 2200 users. Write for details.

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Midwest Delegates Will Hear Talks on Personnel, Planning

Personnel shortages, both nursing and nonprofessional, will be the principal problem for discussion on the first day of the Mid-West Hospital Association meeting in Kansas City, Mo., April 20 and 21.

Opening the nursing section, L. Louise Baker, assistant executive officer directing nursing supply and distribution, P.&A.S., will talk on procurement and assignment of nurses. She will be followed by Minnie E. Pohe, Western Area supervisor, U. S. Cadet Nurse Corps, and Mildred Riese, American Hospital Association, discussing the cadet corps and the nurse recruitment program, respectively. The session will conclude with a talk on payment policy for nurses by Supt. Robert B. Witham, Lincoln General Hospital, Lincoln, Neb.

In the afternoon the delegates will hear Mrs. D. K. Rose; Don S. Hawkins, executive field representative, St. Paul Mercury Indemnity Company, and Everett W. Jones, vice president of The MODERN HOSPITAL, whose papers will be titled: "Volunteers—An Asset to Keep," "Personnel Real-ations" and "Stars in Their Crowns."

Friday morning will be devoted to consideration of future planning, with Dr. Frank R. Bradley, administrator, Barnes Hospital, St. Louis, presiding.

Patients Do Not Cooperate in Group Nursing Program

WASHINGTON, D. C.—Group nursing, proposed in Washington by the District of Columbia Graduate Nurses' Association in November 1944, and tried out by the hospitals in the intervening months, has not met with entire success.

The nurses thoroughly approve the plan and the doctors have given it their backing, said Mrs. Elizabeth Coleman, head of the official registry of the association, but patients have been slow to cooperate.

An appeal has been made to hospital patients to show their patriotism by sharing private nurses in line with the group nursing plan. That some 5000 calls for nurses went unfilled last year on registry records, Mrs. Coleman cited as a cogent argument for the sharing of nurses by hospital patients.

Smith Heads Hospital Council

Dr. Herman Smith of Michael Reese Hospital, Chicago, was chosen president of the Chicago Hospital Council at its recent annual meeting. Dr. Arthur C. Bachmeyer of the University of Chicago Clinics was elected first vice president; Rev. John W. Barrett, diocesan director of Catholic hospitals, second vice presi-

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dent, and Rupert Barry, secretary-treasurer. Directors elected are Dr. Rollo K. Packard, Doctor Smith, E. I. Erickson, Mabel Binner, A. B. Dick and Edgar Blake.

ABOUT PEOPLE

(Continued From Page 72)

John K. Deegan. Dr. Arthur M. Stokes, assistant superintendent of Homer Folks Tuberculosis Hospital, Oneonta, N. Y., has been named to succeed Doctor Lincoln at Mount Morris.

William P. Slover will resign on April 1 after seven years as administrator at Norwegian-American Hospital, Chicago, to become administrator of Manchester Memorial Hospital, Manchester, Conn. A life member of the American Hospital Association, Mr. Slover has also been active in the Illinois association and in the Chicago Hospital Council, of which he has served as secretary of the administrators' section. Mr. Slover will be succeeded at Norwegian-American Hospital by **James Moore,** who will leave Evanston Hospital, Evanston, Ill., to assume his new duties.

Dr. Edwin H. Levine has been appointed director of Winfield Tuberculosis Service, Winfield, Ill., to succeed the late **Dr. Max Biesenthal.**

Department Heads

Mary M. Kurchinsky has been appointed director of nurses at Easton Hospital, Easton, Pa. Miss Kurchinsky was formerly assistant superintendent and director of nurses at Pottsville Hospital, Pottsville, Pa. At the same time it was announced that **Dr. Frederick O. Zillessen** has been appointed medical director of the institution.

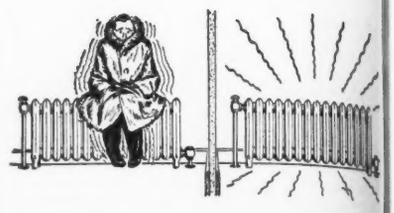
Mary Rinker, R.N., has been named director of nurses at Christian Welfare Hospital, East St. Louis, Ill. Miss Rinker is a graduate of that hospital and has held various positions on the nursing staff for the last thirteen years. **Mrs. Opal Aldrich** has been appointed director of nursing education.

Trustees

Herman Hoffman has been elected president of Adelphi Hospital, Brooklyn, N. Y., succeeding **Herman S. Bachrach.**

Miscellaneous

Harry Sesan, vice president of the Associated Hospital Service of New York, has been assigned the duties of administrator of the hospital department,



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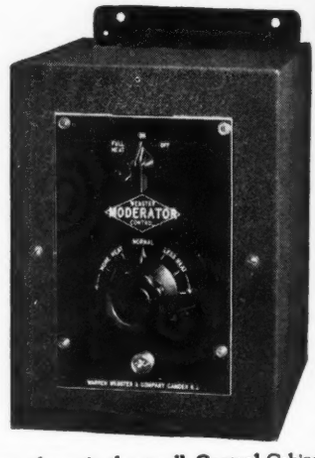

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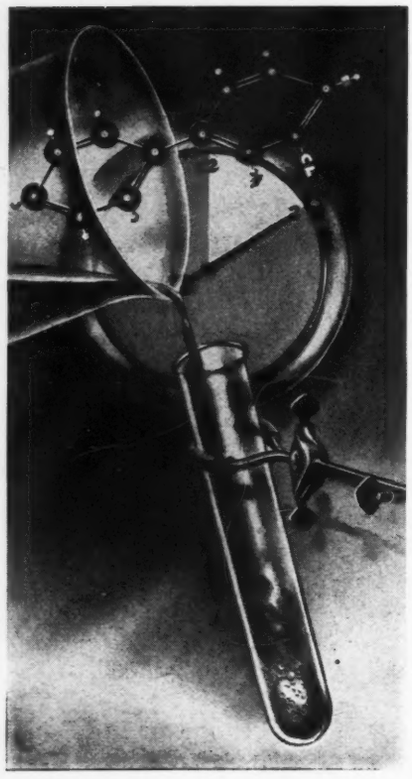

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succeeding the late **Dr. Paul Keller.** Mr. Sesan has been associated with the New York Blue Cross plan since 1939. Prior to this he spent seven years as senior examiner in the New York State Insurance Department.

Emily J. Hicks resigned in February from her position as executive secretary of the New York State Nurses' Association which she had held since 1929. During World War I Miss Hicks was engaged in nursing at Camp Upton and later was director of nursing, successively, at Deaconess Hospital, Buffalo, and Faxton, Utica.

Anne M. Campbell has been named executive secretary of the American Association of Nurse Anesthetists. Miss Campbell has been a teacher at Russell Sage College, Troy, N. Y., for twenty years.

Lt. Col. Nola Forrest, Army Nurse Corps, has been made director of the nursing section, military personnel division, Office of the Surgeon General. Colonel Forrest has been in charge of the nursing service in a field area.

Dr. Jack Masur, surgeon, U. S. Public Health Service, has been assigned to the Office of Vocational Rehabilitation to assist **Dr. Dean A. Clark,** chief medical officer, in the organization and administration of the physical rehabilitation section.

Prof. C.-E. A. Winslow, Anna M. R. Lauder professor of public health at Yale University, has been named editor of the *American Journal of Public Health,* succeeding **Dr. Harry Stoll Mustard.** Doctor Winslow has been identified with the association for many years; he was elected president in 1926 and in 1942 received a certificate for forty years of continuous membership and the Sedgwick Memorial Medal for distinguished service to public health.

Coming Meetings

April 12-13—Southeastern Hospital Conference, Atlanta, Ga.

April 12-14—Hospital Association of Pennsylvania, Hotel William Penn, Pittsburgh.

April 20-21—Mid-West Hospital Association, Hotel President, Kansas City, Mo.

April 21—Oregon Association of Hospitals, Portland.

April 25-26—Iowa Hospital Association, Hotel Fort Des Moines, Des Moines.

April 27-28—Kentucky Hospital Association, Louisville, Ky.

May 8-14—War Conference on Industrial Medicine, Hygiene and Nursing, Hotel Jefferson, St. Louis.

May 10-12—Tri-State Hospital Assembly, Palmer House, Chicago.

May 14-16—Minnesota Hospital Association, St. Paul Hotel, St. Paul.

May 17-18—Carolinas-Virginias Hospital Conference, Battery Park Hotel, Asheville, N. C.

May 22-25—Catholic Hospital Association, St. Louis.

May 22-26—Canadian Medical Association, Royal York Hotel, Toronto, Ont.

June 1-2—National Executive Housekeepers' Association, Bellevue-Stratford Hotel, Philadelphia.

June 6-8—American Nurses' Association, National League of Nursing Education, National Organization for Public Health Nursing, Hotels Statler, LaFayette and Buffalo, N. Y.

June 12-16—American Medical Association, Palmer House and Stevens Hotel, Chicago.

June 26-30—Canadian Nurses' Association, Winnipeg, Man.

Oct. 2-6—American Hospital Association, Hotels Statler and Cleveland, Cleveland.

Oct. 3-5—American Public Health Association, Hotel Pennsylvania, New York City.

Oct. 23-27—American College of Surgeons Clinical Congress, Stevens Hotel, Chicago.

Oct. 25-27—American Dietetic Association, Palmer House, Chicago.

Deaths

John H. McGrath, for sixteen years a member of the board of trustees at Easton Hospital, Easton, Pa., died recently. Mr. McGrath had served as chairman of the hospital's executive committee and also as chairman of the public relations committee.

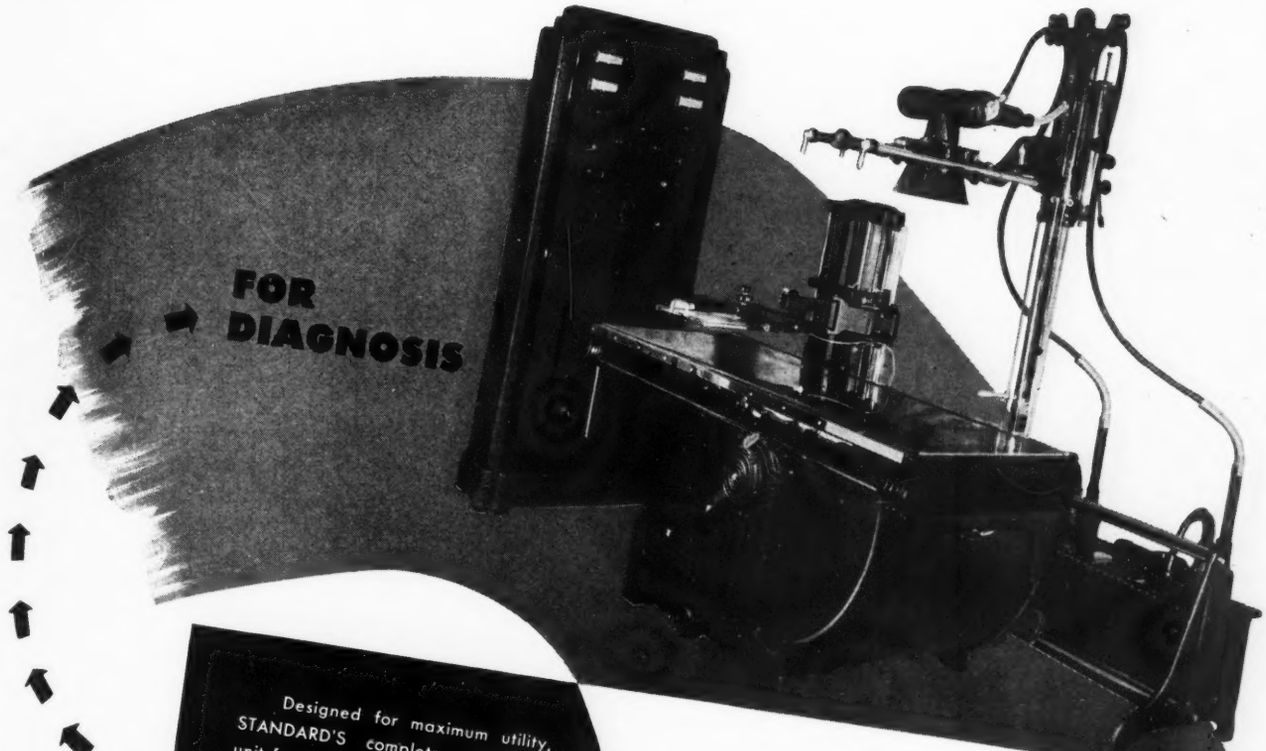
Louis Greenhouse for the last eight years purchasing agent of Jewish Hospital, Brooklyn, N. Y., died recently at the age of 52. Prior to his association with Jewish Hospital, Mr. Greenhouse served for seven years as assistant superintendent of Beth Moses Hospital, Brooklyn.

Dr. M. H. Worthington, superintendent of the University of Illinois Research and Educational Hospitals, Chicago, since 1930, died February 27 of a coronary condition from which he had suffered since 1941. Doctor Worthington became an active personal member of the American and Illinois Hospital Associations in 1932 and in 1943 was admitted to membership in the American College of Hospital Administrators.

Dr. Narley A. Sears, 46, superintendent of the State Home and Training School, Coldwater, Mich., died suddenly on March 6.

Dr. William G. Turnbull, superintendent, Philadelphia General Hospital, died recently at the age of 68, following a heart attack. Doctor Turnbull had been associated with Philadelphia General since 1928 and during the first World War was in charge of the General Hospital at Waynesville, N. C., with the rank of lieutenant colonel.

John H. Hallock for twenty-two years president of Good Samaritan Dispensary and Hospital, New York City, died at the age of 74.



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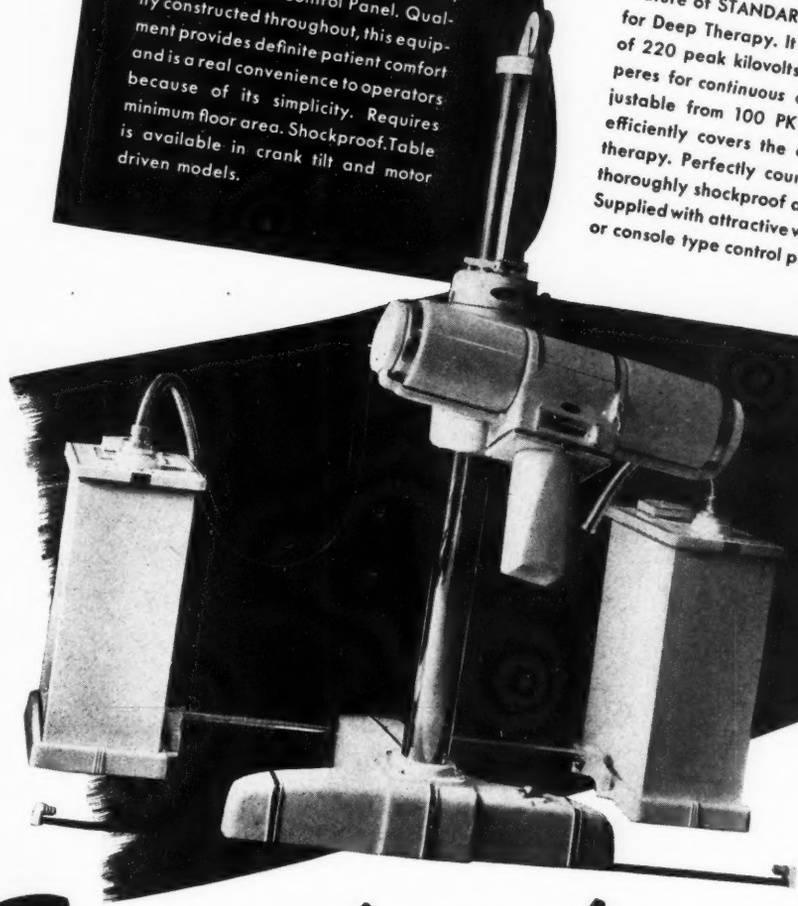

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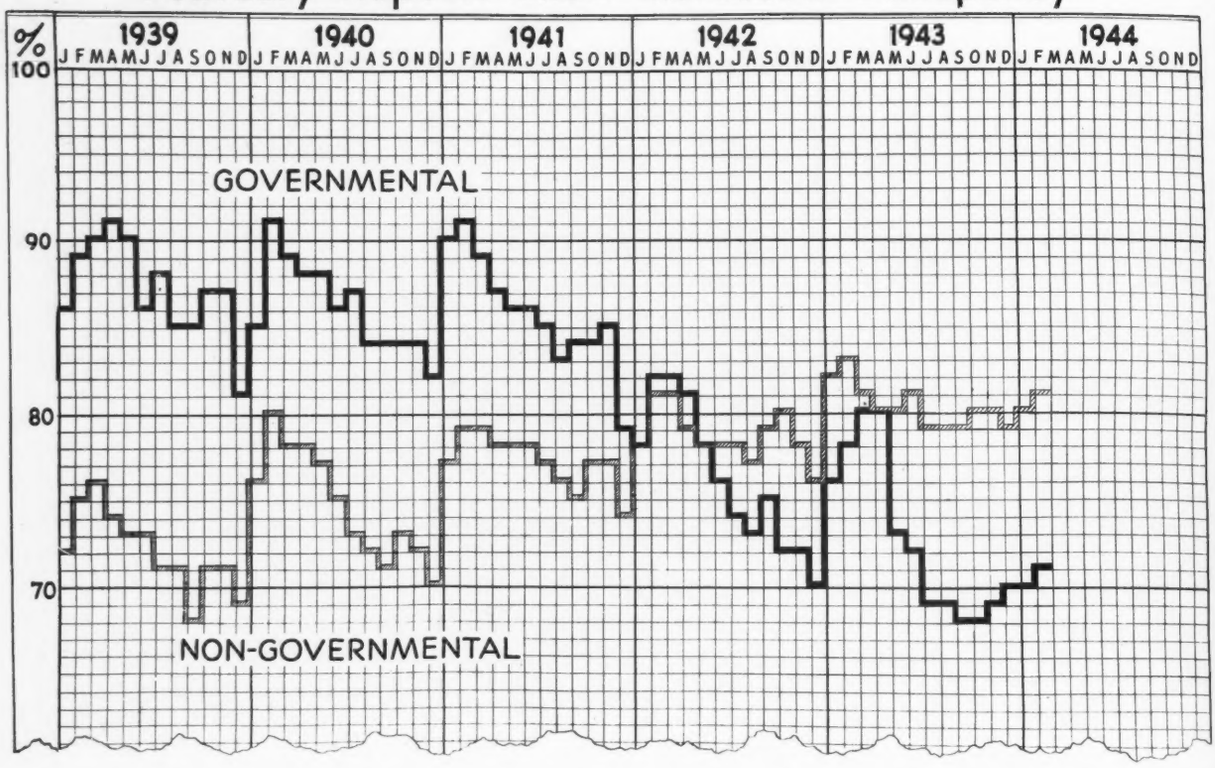
February Reports Show Increased Occupancy



Increased occupancy marked the record for both governmental and nongovernmental general hospitals in February, according to preliminary reports.

The latter continued to have an occupancy that was at least 10 points higher than that of governmental hospitals.

A total of 98 new hospital building projects was reported from February 7 to March 20. Ninety of these gave costs of $9,900,000 bringing the year-to-date total to $24,800,000. Deferred projects have been excluded, thus bringing this figure above last year's net construction total for the corresponding period.

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